Health Insurance in Great Britain 1911-1948

SOCIAL SECURITY SERIES
MEMORANDUM No. 11

RESEARCH DIVISION
DEPARTMENT OF NATIONAL HEALTH AND WELFARE
OTTAWA
MARCH 1952

HEALTH INSURANCE IN GREAT BRITAIN, 1911-1948

Social Security Series, Memorandum No. 11

Published by the Authority of the Hon. Paul Martin
Minister of National Health and Welfare

Research Division
Department of National Health and Welfare

Ottawa

March 1952

FOREWORD

This publication, the fourth in a series dealing with health insurance programs in other countries, has been prepared in the belief that knowledge of Great Britain's experience in this field between 1911 and 1948 has particular relevance for other countries faced with similar problems in the provision of personal health services.

The British program can be described as essentially a sickness insurance scheme for the low and middle income wage-earner, with limited liability as to both the scope and the amount of benefit, based upon orthodox actuarial insurance principles. The limited nature of the health and cash benefits provided, the rigidities inherent in the scheme's financial structure, and the problems arising from the choice of administrative methods, must be viewed in the light of the political and socio-economic environment of the period. More particularly, the unitary political organization of the country, the history of voluntary effort and local tradition in the provision of personal health care services, and the financial and professional resources and institutions available, were all exceedingly important influences on the development of the scheme. While any conclusions on its merits must always be qualified by such considerations, it seems appropriate to draw attention here to a few of the more important results of the application of insurance to the problem of health care as developed in Britain.

M-419
6.52

When viewed retrospectively, the financial and administrative structure of the British program had a clearly discernible effect on its benefit provisions. The choice of a revenue system based on flat-rate contributions, and the important role assigned to reserves and investment income, introduced financial rigidities which resulted in certain inequities for some of the enrolled members. Perhaps the most serious problem in this regard was that the medical and drug benefits, and the cash maintenance payments in periods of sickness or disability, were both financed from the same revenue sources. Thus, if the volume of expenditures on the latter benefits exceeded actuarial estimates, the development of a broad range of health services was automatically limited. Similarly, although personal contributions were made at a uniform flat-rate, the local administrative agency, the Approved Society, was, because of its operation as an autonomous financial unit, forced to restrict its benefits when faced with an adverse sickness experience. Its members were thus penalized for circumstances over which the agency often had very little control. Since the scheme at no time covered more than about 50 per cent of the population, the role of general revenue financing was necessarily limited.

The administrative aspects of the British program are also of special interest. As the bulletin will indicate, the organizational methods employed failed to integrate the insurance health services - general practitioner care and the

provision of drugs - with some of the other components of a health program, such as hospital and specialist care and local public health services. The administration of the scheme through local, financially autonomous Societies might have been expected to achieve certain economies. However, the emphasis on reserves as an indication of the efficiency of a Society's administration, often resulted in advantages or disadvantages to certain insured groups, quite unrelated to administrative efficiency.

While many controversial problems are fairly evident in assessing the program, matters on which there was unanimity of opinion during the life-time of the scheme should not be overlooked. From the outset, the designers of the program consulted with the providers of service, and were therefore in a position, on important matters involving, for example, the remuneration of practitioners or the regional organization of health benefits, to construct the scheme in such a manner as to achieve compromises generally acceptable to all concerned. Furthermore, the fact that the program did make available to about half the population a basic medical service, together with the provision of at least partial reimbursement for income lost during illness, was an important recognition by the state of the problems relating to sickness and its amelioration.

This memorandum has been prepared in close co-operation with the Directorate of Health Insurance Studies.

The comments and suggestions of the officials in that Directorate have been particularly helpful.

The work on this bulletin was carried out by John E.E. Osborne under the supervision of C. Lloyd Francis, Supervisor of the Social Security Section and John E. Sparks who is in charge of public medical and hospital care studies in that section.

March, 1952.

Joseph W. Willard,
Director, Research Division.

M-419
6.52

TABLE OF CONTENTS

LIST OF TABLES

LIST OF CHARTS

I INTRODUCTION

Thirty-five years of experience under a health insurance program preceded the passage of the British National Health Service Act, November 6, 1946. In 1911, the National Insurance Act had provided for a system of compulsory health insurance on a three-way contributory basis, along with a somewhat limited system of unemployment insurance. From 1911 on, Britain developed and extended the use of the contributory insurance principle through measures such as the Unemployment Insurance Acts and the Widows', Orphans' and Old Age Contributory Pensions Acts.

The Beveridge Report of 1942 and the government White Paper of September, 1944, both proposed extension and integration of the existing insurance programs as well as "a comprehensive medical service for each citizen covering all treatment and every form of disability" to be provided where needed "without contributory conditions in any individual case".(1) These proposals were given effect between 1945 and 1948 through the Family Allowances Act, the National Insurance Act, the National Insurance (Industrial Injuries) Act, (which replaced the Workmen's Compensation Act), the National Health Service Act, and the National Assistance Act. A new Ministry of National Insurance was created under the National Insurance Act to administer unemployment benefits, sickness benefits, maternity benefits, widows' allowances, guardians' allowances,

---

(1) W.H. Beveridge Social Insurance and Allied Services, (HMSO, London, 1942), pp. 48, 159.

retirement pensions, and death grants; other misfortunes which might prevent a person from earning his own living are covered under the National Assistance Act. The National Health Service Act, which came into operation July 5, 1948, extended to everyone free medical treatment, including specialist services and dental, ophthalmic, and hospital treatment, and brought hospitals under public ownership.

The most significant aspects of the new National Health Program are that free medical service is no longer limited to employed insurance contributors, but is extended to every person in Great Britain, irrespective of income or insurance status; that medical benefits now include specialist and hospital treatment; that sickness cash benefits, no longer administered by the Friendly Societies, are separate from medical benefits in both their administration and finance; and that the scheme is financed mainly from general tax revenues, rather than from joint employer-employee contributions. Only one-tenth of the weekly insurance contributions are used to support the National Health Service. The significance of divorcing medical services in Great Britain from the insurance system can best be appreciated in relation to the pattern of health services before 1948. This bulletin consists of a general description of the National Health Insurance system from 1911 to 1948, together with a brief outline, from authoritative sources, of some of the main difficulties encountered and criticisms made.

The choice of suitable statistical material for illustration has posed certain problems. The lack of published material concerning the wartime experience of the program, coupled with the transfer of insured persons from civilian employment to the armed services, and the distortion of that information which is available by the war-induced increases in prices and employment has prevented the use of figures from this period. In the post-war years interest was focussed on the new National Health Service, and only limited information is available on the last years of National Health Insurance. In consequence, most of the illustrative material used in this report applies to the calendar year 1938, with the corresponding figures for 1947 added wherever possible.

No attempt has been made to convert the financial data from pounds to dollars. Over a thirty-five year period, the value of the pound sterling in Canadian dollars has fluctuated with the vicissitudes of foreign trade and the fiscal and monetary policies pursued, which have little relevance for the health care needs and resources of a nation. But, more important than this, a significant comparison between the values of two currencies cannot be made without detailed knowledge of the price levels, cost of living, distribution of incomes, and population structure in both countries. Because of this fact, percentages of total expenditure have been used wherever possible to place the component parts of the program in their proper relationship with one another.

With a population of 48 million persons in 1947, Great Britain covered an area of 94,200 square miles - the size of Canada's four Atlantic Provinces, exclusive of Labrador. Each square mile thus had to accommodate an average of 512 people, varying from 169 in Scotland to 738 in England and Wales. Since the sickness experience and the efficient use of the health resources of a nation are directly influenced by the density and age distribution of the population, it should be kept in mind that the British population, 80 per cent urban since the inception of the health insurance scheme in 1911, has been ageing over the period. In 1911, 31 per cent of the people were under 15 years, while 5 per cent were 65 years or over. By 1947, the last complete year of operation of the health insurance program, only 21 per cent were under 15, while 11 per cent were 65 years of age or over.

In evaluating the expenditures under the British program, it is helpful to know that prewar net national income at factor cost for the whole United Kingdom, which was £4,638 millions in 1938, or an average of £97.65 per person, had almost doubled by 1947 when it stood at £9,071 millions, or £183.11 per person. The average industrial wage for adult males in 1938 was £179.4 annually, or 69 shillings a week. This fact is also of interest in the light of the program's major emphasis on cash sickness benefits.

II HISTORICAL DEVELOPMENT OF NATIONAL HEALTH INSURANCE

The National Insurance Act of 1911, Part I of which established the British system of health insurance, was precipitated by the Majority and Minority Reports of the Royal Commission on the Poor Laws in 1909. Both Reports had recommended that an insurance scheme be set up to provide cash sickness benefits for ill or disabled workers. The Majority Report recommended that medical assistance be organized on a private charity basis with an extension of the contract system of the sickness clubs; the Minority Report suggested that the medical services of the county public health authorities furnished the only proper basis for a unified state medical service.

The British Medical Association opposed both suggestions because under the latter "a free medical service open to all might result, which would cut the very foundation of private practice"; under the former the Association feared an extension of the evils of contract practice, a system whereby private lay and industrial groups contracted with doctors to treat their members at very low rates, usually 5 shillings per capita per annum. Instead, the Association recommended a "Public Medical Service", organized and administered by the profession, for the lower income classes.

The program of health insurance eventually adopted in 1911 represented a compromise between several of these

conflicting proposals. Writing retrospectively in 1925, Sir Arthur Newsholme[1] stated "the two reports of the Royal Commission on the Poor Laws embodied an urgent body of needed reform, on which there was no argument...Instead of this, the National Health Insurance Bill was introduced in 1911, which necessarily ran athwart the needed course of development in Public Health Administration...The ideal would undoubtedly be to nationalize the health insurance service as the unemployment and pensions service have been nationalized". A similar view was expressed by the Royal Commission on National Health Insurance in 1926.[2]

The summary which follows indicates the final provisions of the 1936 Act, as amended, on the eve of nationalization of the health services in 1948. The major changes in the scheme since 1911 are then described in the next section.

SUMMARY OF THE 1936 ACT AS AMENDED

The National Health Insurance scheme was a state scheme which relied for its administration on voluntary effort, and which, in intention, was careful to make the utmost use of the voluntary and competing organizations already in the field. Subject to certain exceptions, all persons between the ages of 16 and 65 years[3] who were employed

---

(1) Formerly Principal Medical Officer of the Local Government Board of England. See A. Newsholme, The Ministry of Health, (1925), pp. 186, 203.

(2) See p. 131.

(3) 70 years until 1928.

under a contract of service in manual labour, or in non-manual employment at a rate of not more than £420 a year,(1) were required to be insured as employed contributors. Persons who had been employed and insured for at least two years might, on ceasing to be insurably employed, continue in insurance as voluntary contributors, paying the full weekly contribution themselves. Employed persons between the ages of 14 and 16 years, and over the age of 65 years, were required to be insured for medical benefits only.

The benefits provided under the Act were:

(i) Medical benefits, including medical treatment by insurance practitioners at home or in the office, and the provision of medicines and supplies;

(ii) Sickness cash benefits, during incapacity for work through illness, amounting to 18s. a week for men, 15s. for spinsters and widows, and 13s. for married women,(2) for a maximum period of 26 weeks;

(iii) Disablement cash benefits for continued illness after 26 weeks of sickness benefit had been exhausted, amounting to 10½s. for men, 9s. for spinsters and widows, and 8s. for married women;(3)

---

(1) The income limits were £160 until 1920 and £250 until 1942.

(2) 10s., 7½s. and 7½s. until 1920; 15s., 12s., and 12s. until 1933; 15s., 12s., and 10s., until 1942.

(3) 5s. for both sexes until 1920; 7½s. until 1933; 7½s., 6s., and 5s., until 1942.

(iv) Maternity cash benefits, payable on the confinement of an insured woman or the wife of an insured man, and amounting to £4 in the former and £2 in the latter case;(1) and

(v) Additional benefits, payable to members of those societies having a disposable surplus upon quinquennial actuarial valuation, and taking the form of increased cash benefits or part-payment for specialist, dental, ophthalmic, or hospital treatment.

The financing of the scheme was shared by the insured persons, their employers, and the National Exchequer. Weekly contributions of 11d. for men and 10½d. for women,(2) shared equally by employees and employers, were paid into the National Health Insurance Fund by means of health insurance stamps purchased through the Post Office. The contribution rate was set so as to cover the costs of benefits that persons entering the scheme at age 16 years were expected to claim throughout their lifetime. To meet the deficits incurred by the Fund on behalf of persons entering at ages above 16 years, with a higher incidence of illness, Exchequer grants, amounting to 1/7 of the cost of benefits and

---

(1) £3 and £1½ until 1920.

(2) 7d. and 6d. until 1920; 10d. and 9d. until 1926; 9d. and 8½d. until 1942.

administration in the case of men, and 1/5 in the case of women, were provided.

The administration of the scheme was supervised by the Ministry of Health and the Department of Health for Scotland. Medical benefit was administered by 200 specially-appointed, regional Insurance Committees, consisting largely of representatives of insured persons and insurance practitioners. Cash benefits and additional benefits were administered by 8,000 self-governing Approved Societies and branches, which varied in membership from 50 to more than 2,000,000 insured persons. These friendly societies and trade union benefit associations, which had no regional limitations, had already enrolled one-third of the insurable population in their voluntary schemes before the 1911 Act was passed. Insured persons who did not or could not join Approved Societies paid their contributions into a Deposit Contributors' Fund, and were entitled to medical benefits, and to limited cash benefits up to the amounts credited to them in their individual accounts.

DEVELOPMENT OF THE SCHEME

The Act of 1911, described in its Preamble as "an Act to provide for insurance against loss of health, and the prevention and cure of sickness", underwent several amendments during its lifetime, aiming either at simplication of its provisions and administration, or at correction of certain inadequacies and inequities which arose over the period of its operation. These amendments were consolidated in the

National Health Insurance Acts of 1924 and 1936. With the exceptions outlined below, the amendments changed the basic structure of the 1911 Act only to a very limited extent.

Prior to the report of the Royal Commission appointed in 1924 to investigate the program, certain changes mainly affecting coverage were implemented. An important amendment in 1918 restricted voluntary membership to former "employed contributors" or persons in excepted employment. Prior to 1918 voluntary membership had been available to those non-manual workers in regular occupations not receiving remuneration under a contract of service. At no time during the operation of the scheme was an income limit placed on eligibility for membership of manual workers. However, amendments in 1919 and 1920 increased the income limit from £160 to £250 for non-manual workers, and in addition, prolonged insurance status in certain cases of hardship due to post-war unemployment.

Several of the recommendations(1) of the Royal Commission were given effect in the National Health Insurance Acts of 1926 and 1928. Most important was the provision that individuals who had been unable, by reason of their health, to secure admission to Approved Societies because they were considered as adverse risks, and had thus been eligible for only limited benefits as Deposit Contributors, would

(1) Report of the Royal Commission on National Health Insurance, Cmd. 2595, (London: HMSO, 1926), pp. 274-291.

henceforth be entitled to all the normal benefits of the Act. In addition, a minor expansion of coverage was effected by the extension of the earlier provision with respect to those persons engaged in manual labour to include manual workers who technically were not employed under contract of service -- for example, such categories as tree-fellers, hay-cutters and share fishermen.

Important modifications were also made, following the recommendations of the Commission, with respect to anomalies concerning benefits and their duration for certain classes of insured persons. Under the earlier Act, insured women who had ceased work on marriage were transferred to a special class (Class K) with limited benefits, particularly a reduction in the rates of the ordinary sickness benefit, and in the maternity benefit when such persons were in arrears of contributions. In 1928, legislation embodied the Commission's recommendation that such persons should receive the ordinary rates of sickness benefits and maternity benefits irrespective of arrears. In addition, provision was made that a person would be considered to be insured during a period when arrears were due to genuine unemployment, and additional Exchequer grants would be provided to Societies to meet the loss of premium income. This cancellation of the arrears of genuinely unemployed insured persons allowed them to be treated as though they had paid 26 contributions (the minimum number) and to be entitled to benefits on a reduced scale. Full benefits could then be attained by the payment

of a smaller arrears penalty than would otherwise have been required.

The legislative enactments following the Royal Commission's recommendations (1926, 1928) also effected certain financial and administrative changes. The temporary Exchequer grants extended to meet rising costs during the early 1920's were discontinued, and weekly contributions were re-allocated between benefits and reserves in order to release sufficient funds to meet the cost of medical benefits wholly out of contributions, except for the statutory Exchequer grants. Certain recommendations were also accepted which gave additional power to the Minister, including the right to order a reduction of the amount allowed an inefficient Society for administration, to amend any rule to which exception was taken, to suspend the right of any Society to accept transfer members, and to enforce uniform and efficient administration of additional benefits by disallowing improper expenditures.

It is interesting to note the Commission's recommendations with respect to broadening first the scope of medical benefits, including specialist consultations and laboratory service and later the provision of a maternity medical and midwife service,(1) and dental treatment. These extensions, together with the proposed increase in sickness and disablement benefits to include supplements for

---

(1) In 1937 a domiciliary midwife service was established by the Local Health Authorities, under the Midwife Act of 1936.

dependents, would have been financed, under the Commission's recommendations, by allowing half the surpluses of Approved Societies to be pooled and distributed among all Societies at a uniform rate per member. However, the recommendations accepted were concerned more with the consolidation of the existing Act than with the expansion of its coverage and benefit provisions. No attempt was made to implement the Commission's belief that unification at the local level should be attained by the elimination of the Insurance Committees and the transfer of their duties to the Local Authorities.

Two amendments of 1933 deserve special notice. Differential rates of sickness benefit were established as between single and married women as a result of experience which indicated that employed married women constituted a greater insurance burden. Further, insurance practitioners had been required to supply those drugs necessarily administered by themselves, in return for a special capitation payment. As of 1933 they could prescribe these drugs as part of the regular pharmaceutical benefits or claim payment from the local Insurance Committee if they themselves supplied such drugs.

In 1938, in accordance with a recommendation made in the Minority Report of the Royal Commission, Juvenile Contributors between the ages of 14 and 16 years were admitted to medical benefits under the Act in return for a weekly contribution of 4d. shared equally between the employer and the employee. Employer contributions of 5½d. on behalf of

employees aged 65 years or over, who were still eligible for medical benefits only, were required for the first time in 1938. In the same year, Dental Benefit Regulations were passed setting forth the maximum fee scale and standards of quality for dentists who agreed to provide treatment additional benefits to insured persons;(1) by 1946, the minimum proportion that a Society must pay for such services was reduced from one-half to two-fifths of the cost of dental treatment.

Compulsory health insurance, then, covered manual labourers, non-manual labourers within the income limit, and juvenile contributors. Voluntary insurance, after persons in certain excepted employments had been barred from entry in 1937, was limited to persons with at least two years' previous insurance status. Thus, by 1942, only four classes of insured persons remained within the scheme: manual and non-manual labourers, voluntary contributors with prior insurance status, and juveniles. With the exception of an increase in the income limit for non-manual workers in 1942 from £250 to £420, no further modifications were made with respect to extending coverage or benefits under the Act.

---

(1) Dental benefits had been provided by some Approved Societies since 1921, but this was the first attempt to regulate the treatment provided.

III HEALTH CARE SERVICES

To understand the role of health insurance during this period, it seems helpful to review the other health services provided by voluntary and public authorities in Great Britain. No less than seven government departments were responsible for the provision or supervision of public health services prior to consolidation under the National Health Service Act, 1946. The health of merchant seamen, of miners, and of industrial workers was the responsibility of the Ministry of Transport, the Ministry of Fuel and Power, and the Ministry of Labour, respectively. The Ministry of Education provided for the medical inspection of school children, and the Ministry of Food was responsible for nutrition. Finally, the Ministry of Health and the Department of Health for Scotland supervised health insurance, town planning, and, through the Local Authorities (who were responsible to them), mental health, infectious diseases, maternal and child welfare, housing, and the basic sanitary services. For the most part, the Local Authorities were free to adapt the minimum standards set forth in the various Acts to their own needs; their services were provided partly at local and partly at national expense.

The following is a brief outline of certain specific health services(1) that were provided.

---

(1) Cf. Ministry of Health, A National Health Service, (H.M. Stationery Office, London, February, 1944), Appendix A; U.K. Information Office, Health Services in Britain, (Ottawa, October, 1947).

MATERNAL AND CHILD HEALTH SERVICES

Maternity and Infant Welfare schemes organized after 1918 by the Local Authorities were financed by national grants-in-aid. In 1938, 1,500 of the 1,800 pre-natal clinics giving free examinations and advice were provided by the Local Authorities, who also employed over 3,600 of the 6,000 qualified health visitors, and 2,700 of the 10,000 practising midwives. In addition to supervising 91 maternity homes and 338 hospitals with maternity wards, and subsidizing 142 voluntary institutions, the Local Authorities by 1938 had set up over 2,700 of the 3,600 infant welfare centres, 24 children's hospitals, and approximately 20 of the 104 day nurseries for children of working parents. By 1946 there were 1,358 day nurseries being run by the Authorities at Central government expense.

The School Medical Service was conducted by School Medical Officers appointed by the local Education Authorities. In 1939 there were 1,656 such officers in Great Britain, as well as the equivalent of 865 full-time dentists and (in England and Wales) 2,797 full-time nurses. These officers conducted, in school clinics at local expense, the required examination of elementary school children and the optional examination of secondary school pupils. If necessary, free treatment was also provided.

MEDICAL, DENTAL AND OTHER SERVICES

Medical care was provided for nearly half the population by traditional arrangements between patient and

doctor, and for an almost equal number (23 million) by national health insurance. The "destitute sick" were provided for under the Poor Law. Some of the traditional arrangements included contracts between the doctors who were paid a per capita fee, and Friendly Societies,(1) trade unions, or sick clubs for non-insured persons. The British Medical Association sponsored the Public Medical Services,(2) under which scheme 600,000 weekly subscribers to a central fund were given medical services by member doctors who were remunerated according to the number of subscribers registered with them, the average annual capitation fee in 1937 being 11s. 3d.

Dental services in varying degree were provided by the Local Authorities or the Education Authorities to nursing or expectant mothers, young children, school children, and T.B. patients. Mothers were expected to pay part of the cost of dentures, and treatment for school children was by no means adequate. Roughly three-fourths of the workers covered by Health Insurance were eligible for "dental benefits" -- money payment for part of the approved cost of dental treatment.

Ophthalmic services constituted one of the most comprehensive branches of school medical work. Apart from

---

(1) For example, in 1936 1.4 million members of the National Deposit Friendly Society were entitled to aid up to a fixed sum in meeting their doctor bills.

(2) See Report on the British Health Services, (Political and Economic Planning, London, 1937) p. 153. Weekly premiums ranged from 4d. for a single subscriber to 1s. for a family of 4 or more.

this, the only other persons receiving assistance in meeting the cost of ophthalmic examination and treatment, or of spectacles, were the 12 million members of those Approved Societies which were able to offer "ophthalmic benefits".

Home Nursing Services were provided mostly through the district nursing associations, voluntary organizations employing over 9,000 nurses in 1939. Although the Local Authorities had only limited power to employ nurses directly as health visitors or midwives under the infectious disease and maternal and child welfare legislation, they did assist the voluntary groups financially. In addition to these grants, the associations received donations and subscriptions, and payments from patients either directly or through contributory schemes.

HOSPITAL SERVICES

Hospitals in Britain were run by both voluntary organizations and Local Authorities. Until 1930 in England, and until 1948 in Scotland, the former carried the main burden of providing hospital treatment for acute medical and surgical conditions. The latter handled most cases of infectious disease, maternity, and chronic care. Hospital services were not included in those statutory benefits to which insured workers were entitled. However, over ten million persons were covered by private hospitalization schemes in 1939, a weekly payment of from 2d. to 6d. entitling them to complete care and treatment. Others arranged, at their own expense,

to enter private rooms in voluntary hospitals or private nursing homes. The remainder obtained, usually through their family doctors, hospital care and specialist advice at their local voluntary or municipal hospitals, paying what they could reasonably afford for this service.

Tuberculosis institutions -- dispensaries, hospitals and sanatoria -- were provided by Local Authorities and voluntary groups. Since 1921 the Local Authorities have been responsible for treatment and after-care for all victims of the disease. In addition they make grants to private groups like the King Edward VII Welsh National Memorial Association.

In 1929 the Local Authorities, who were responsible for isolation as well as immunization and disinfection of infectious diseases, were compelled to work out a scheme for adequate isolation accommodation. As a result 920 public isolation hospitals were providing free treatment by 1939. Supervision of contacts was directed by the Medical Officer of Health in each locality. From 1916 on, the Local Authorities gave free venereal disease treatment in 200 clinics and centres in Britain.

Mental Health Services in Britain were supervised by the Board of Control, and the Board of Control for Scotland, semi-autonomous bodies responsible to the Ministry of Health or the Secretary of State. The actual care and treatment of mental patients was the responsibility of the Local Authorities, who provided mental hospitals, licensed existing hospitals, and inspected and certified institutions and homes caring for the mentally deficient.

OTHER SPECIAL SCHEMES

The Highlands and Islands (Medical Service) Scheme set up a central fund -- replenished from general revenue -- to pay grants to doctors in seven remote counties of Scotland, for their travelling and time, to attend at uniform fees irrespective of distance all insured persons, their dependents, and uninsured persons who could not afford full fees. The Department of Health entered into an agreement directly with each doctor, but there was no detailed control of the doctors' activities. In 1943 the fund paid out £100,000 to subsidize 153 practices, an air ambulance service, and housing and travel for 200 district nurses.

The Clyde Basin Experiment, 1942, was originated to conserve manpower in Clydeside, and continued after the war as the Supplementary Medical Service Scheme. A patient who was run down in health was sent by his family doctor to a specialist, and then, if necessary, to a hospital or convalescent home.

IV HEALTH RESOURCES

Before examining in detail the National Health Insurance program of Great Britain, it is desirable to consider briefly the personnel and facilities which served as the foundation for this program as well as the health care services described in the previous chapter. In the following, an attempt is made to compare the pre-1939 and post-war situations wherever possible.

GENERAL PRACTITIONERS

It is extremely difficult to obtain an accurate estimate of the number and distributions of general practitioners in Great Britain. Of 41,700 "physicians, surgeons, and registered medical practitioners" in Great Britain listed in the Medical Directory for 1937, probably only 35,000 were in active practice.(1) Of these, approximately 19,000 were general practitioners under the insurance program. Since not all general practitioners were on insurance panels, there is no means of ascertaining their total number. At the outset of the National Health Service scheme, as of June, 1948, there were approximately 23,000 general practitioners in Great Britain. The pre-war average population per general practitioner was approximately 2,250,(2) ranging from a low of 585 in the city of Hampstead to a high of 4,105 in South Shields.

(1) Report on the British Health Services. (PEP. London, 1937), p. 141.

(2) The British Medical Journal, August 26, 1950, estimates the 1939 population per active general practitioner to have been 2,770 in England and Wales, and 2,652 in Scotland, as compared with 2,402 and 1,939 respectively for 1949.

SPECIALISTS

The 1945 Hospital Survey Reports for England and Wales(1) revealed that the distribution of specialists was dependent on economic conditions, rather than on medical needs; it was determined largely by the opportunities for making a satisfactory income from private practice. To overcome this difficulty, many hospitals appointed salaried part-time specialists to their staffs; often a local authority and a voluntary hospital would collaborate in making appointments to the staffs of both hospitals. Although a few of the larger hospitals were staffed exclusively by specialists, most hospitals were staffed wholly or partly by general practitioners who became recognized as consultants. "The Reports are agreed on the need for a much wider distribution of specialists. At present, they are unduly concentrated in the medical school centres. While general surgeons, ear, nose and throat surgeons, ophthalmic surgeons and gynaecologist-obstetricians are to be found in many other towns, their distribution is uneven and haphazard; physicians and dermatologists are scarce and paediatricians not to be found outside the university centres."(2)

DENTISTS

As of 1921 the practice of dentistry was confined to duly registered medical or dental practitioners. Registration

(1) Special expert surveys conducted under the auspices of the Ministry of Health and the Nuffield Provincial Hospitals Trust.

(2) Report of the Ministry of Health for 1945-6, Cmd. 7119, (HMSO., London, 1947) p. 67.

required at least four years' professional training, including two years in a dental hospital or equivalent. In 1937 there were 14,700 persons on the Dental Register, of whom over half held dental degrees. This number includes, however, Irish and overseas members of the profession, as well as those who had retired. In June, 1948, there were 10,000 dentists in England and Wales, and 1,200 in Scotland, available for active general practice. The Teviot Committee on Dentistry(1) in 1946 indicated the need to treble the normal pre-war annual intake to the Dentists' Register if the goal of 20,000 practising dentists was to be reached within 20 years. This Committee also recommended self-government under an independent Dental Council for the profession which until December 1951 was subject to the control of the General Medical Council.(2)

NURSES

The general and special hospitals suffered after the war from a lack of both nursing and domestic staff. As of March 31, 1946, there were 23,500 notified vacancies for nursing staff in the hospitals of England and Wales, and during the previous year there had been as many as 32,000 vacancies at one time. As a result, some wards were closed, and many chronic patients were refused admission.

---

(1) Ministry of Health, Final Report of the Inter-Departmental Committee on Dentistry, (HMSO, London, 1946), pp. 5-6.

(2) A semi-public organization of 39 members, mostly practitioners, appointed or elected by the Crown, the medical colleges, the medical corporations, and the medical practitioners of the United Kingdom.

Despite measures taken to combat the situation, including a nation-wide recruitment campaign, the shortage continued throughout 1947. Salary scales were revised in January, 1946, and special allowances were offered to persons with at least one year's whole-time service in work of national importance who entered training as student nurses. Student nurses on graduation were required to spend one year in tuberculosis, mental, or chronic sick nursing. Pre-nursing courses were established by the local Education Authorities, and the district nursing field was opened to male nurses. Although these measures produced a considerable increase in the number of student nurses, wastage was high; hospital beds (particularly in sanatoria) had to be closed, and the ratio of nurses to occupied beds dropped. By 31 March, 1948, there were 41,394 student nurses in training, and 16,500 part-time and 140,000 full-time nurses and midwives in England and Wales.

HOSPITAL FACILITIES

Each voluntary hospital, from the large and powerful "general" to the small "cottage" hospital, was administered by its own Court of Governors, assisted by a Board of Management and several Standing Committees. It was financed from voluntary subscriptions or endowments, prepaid hospital schemes, and patient fees. In England a social worker would usually assess the amount a patient could pay. In Scotland, treatment was traditionally free, and there were few contributory schemes. Voluntary gifts amounted to approximately 18 per

cent of the operating income of voluntary hospitals of Great Britain in 1944, while receipts for services rendered represented 64 per cent.

In 1929, the Local Government Act required County Councils to provide general as well as infectious disease hospitals. To comply, many Poor-Law institutions were appropriated by the councils, and administered together with the infectious disease hospitals through Local Authority Public Health Committees. By statute, the authorities were required to charge what the patient could reasonably afford, except in infectious disease cases which were treated free of charge in many areas. In addition, the public hospitals were financed by Exchequer grants, local taxation, and hospitalization schemes.

Estimates of pre-war hospital accommodation vary considerably, but approximate figures for the number and bed-capacity of hospitals in Great Britain in 1939 are given in Appendix I. Roughly 54 per cent of 1,300 general hospitals in England and Wales, and 31 per cent of 2,200 specialized hospitals (excluding 163 mental hospitals) were voluntary institutions before the war. These establishments contained 324,000 beds, the greater proportion (54 per cent) in the general hospitals. Of 37,000 pre-war (non-mental) hospital beds in Scotland, 22,000 or 60 per cent were in voluntary hospitals.

The distribution of hospital beds per 1,000 population in 1937, and the estimated bed requirements for various

purposes, in selected areas of England and Wales are given in Appendix II. The actual supply of general hospital beds available in 1937 was 4.3 per 1,000 population, varying from 6.27 per 1,000 in the London region to 3.48 in the South Wales region.

The Hospital Survey Reports in 1945 showed a definite shortage of hospital beds in every region, notably for maternity and tuberculosis cases. The reports stressed that many hospital buildings were out of date and fell far short of modern requirements, for there had been little hospital building since 1914. Also it was pointed out that, due to overcrowding, hospital capacity was over-stated by about 20 per cent. The following quotations are extracted from these reports(1):

> "Voluntary hospital equipment is generally good, but has had to be housed in cramped space."
>
> "The municipal general hospitals are mostly converted poor law institutions, and tend to be even older than the voluntary hospitals.....Most of them are attempting to perform a function for which they were not designed and are not suited.....There is a lack of single-bed wards and of accessory rooms, and sanitary accommodation is unsatisfactory."

One report stressed the poor, inconvenient and cramped accommodation in the out-patient departments. And again, "the care of the chronic sick requires complete and revolutionary change if these people are to be adequately

(1) Report of the Ministry of Health, 1945-6. Cmd. 7119 (HMSO, London, 1947) pp. 63-81.

cared for and looked after in a reasonably humanitarian and social sense." However, even with an adequate supply of beds, the capacity of a hospital to accommodate patients was limited by the availability of nursing and domestic staff.

In March, 1948, there were in England and Wales altogether 516,494 beds in all hospitals, including 58,914 beds temporarily unavailable(1), or 298,672 hospital beds of all types except mental and tuberculosis beds (as shown in Appendix III) amounting to 6.87 per thousand population. The corresponding figure for Canada was 5.0 per thousand in the same year, ranging from 6.9 in Alberta to 4.0 in Newfoundland. However, due to the nursing shortage in Britain, only 5.77 staffed beds were available per thousand population.

On July 5, 1948, ownership of 2,835 out of the 3,040 voluntary and municipal hospitals in England and Wales (including convalescent homes and certain types of clinics), with a total of 388,000 staffed beds, became vested in the Minister of Health. Not taken over were 277 hospitals and clinics, belonging mostly to religious communities, and public assistance institutions used predominantly for accommodating the infirm rather than the sick. In Scotland, 425 hospitals containing 63,880 beds were taken over by the Secretary of State for Scotland to be operated under the new National Health Service.

---

(1) Report of the Ministry of Health, 1947-8, Cmd. 7734, (HMSO, London, 1949). Appendix D, p. 276.

V HEALTH INSURANCE COVERAGE

EMPLOYED PERSONS

The National Insurance Act of 1911, and the National Health Insurance Act of 1936 as amended, required that all persons between the ages of 16 and 65 years, including married women and aliens, be insured if engaged in any employment under a contract of service or under a contract of apprenticeship with a money payment, and remunerated at a rate not exceeding £420 a year. Also required to be insured were "certain persons employed under a contract for the performance of manual labour for the purposes of an employer's trade or business, outworkers, cab drivers and fishermen and other seamen paid by the share".(1) Where the employment was in manual labour there was no maximum limit on income.

(1) Married Women

The special position under the Act of female members of Approved Societies under the age of 65 who married may be summarized as follows:

(i) Voluntary contributors ceased to be entitled to make contributions immediately upon marriage, and became eligible for Class K benefits.

(ii) Employed contributors who continued in employment for 12 months following

(1) See National Health Insurance Act, 1936, First Schedule, Part I.

marriage were treated as ordinary insured persons.

(iii) Employed contributors who ceased employment[1] within twelve months following marriage ceased (from the date of unemployment or from the date of marriage, whichever was the later) to be entitled to the normal benefits of the Act, and became entitled to Class K benefits instead.

In 1938, 379.500 married women were entitled to Class K benefits.

(2) Juveniles

The National Health Insurance (Juvenile Contributors and Young Persons) Act, 1937, required juveniles between the ages of 14 and 16 in insurable employment to have health insurance contributions of 4d. paid on their behalf by their employers (of which 2d. was recoverable from the juveniles), although they were entitled only to the medical benefit provisions of the Act. Upon reaching the age of 16, employed persons automatically passed into adult contributor status; medical benefits continued, even if the juvenile ceased insurable employment, until the age of 16½. In 1938, the first year of operation of this Act, approximately 848,700[2] juveniles in Great Britain were estimated to have been covered.

(1) A woman was deemed to have ceased employment as soon as she had been voluntarily unemployed for eight consecutive weeks.

(2) Twentieth Annual Report of the Ministry of Health, (London, 1939), pp. 275, 299 and Tenth Annual Report of the Department of Health for Scotland, (1938, Edinburgh), pp.133,231.

(3) Exemptions and Exceptions

(a) Exemptions

An employed person obtained exemption from paying compulsory health insurance contributions by proving (i) that he was in receipt of an annual pension or private income of not less than £26, not dependent on his personal exertion, (ii) that he was "mainly" dependent for his livelihood on another person, or (iii) that his insurable employment was not his chief occupation.

Employed persons who obtained exemptions were entitled under certain conditions to medical benefits, but not to sickness, maternity, or disablement benefits. The employer was still required to pay his share of the ordinary contributions on behalf of exempted persons. At December 31, 1938, there were only 13,850 persons in the exempt category in Great Britain.(1)

(b) Exceptions

Various classes of employed persons were not liable to compulsory insurance contributions, nor eligible for insurance benefits. These included employees of the Crown, Local Authorities, public railways and other statutory companies, where the Minister of Health had certified that the terms of employment would secure benefits in sickness and disablement of at least an equal value to the corresponding health insurance benefits; certain classes of school teachers; commission agents employed by one or more than one employer,

(1) Ibid.

and others mainly dependent on some other occupation for their livelihood; casual labourers employed otherwise than for the employer's trade or business; those employed by parents or by an employer who fully maintained the employee; and persons in the service of their husbands or wives. Apart from the above exceptions, "the fact that an employment (was) temporary or for part-time only did not affect the question of liability for insurance."(1)

VOLUNTARY COVERAGE

After 1937, voluntary insurance was limited to persons who had once been compulsory contributors. The original Act in 1911 had admitted to voluntary insurance all persons ceasing insurable employment after five years of contributions had been paid, and other persons engaged in some regular occupation with an income not exceeding £160 a year. As there was practically no demand for insurance on a voluntary basis, admission to this category was limited in 1918 to persons ceasing insurable employment with two years of contributions to their credit, or, upon the approval of the Ministry of Health, to persons engaged in one of the excepted employments noted above, earning not more than £160 a year(2) if they were non-manual labourers. Finally, in 1937, admission to voluntary insurance was also denied to these persons in excepted employment. Married women, after the first few years, were not permitted to become voluntary contributors.

(1) R.W. Harris, National Health Insurance in Great Britain 1911-1946. (Geo Allen & Unwin, London, 1946), p. 18.
(2) After 1920 the income limit was £250.

Voluntary contributors paid the whole contribution; this was reduced by 3d. a week where the contributor's income from all sources exceeded £420 a year because persons above this maximum income level were not entitled to medical benefits. Of the 840,640 voluntary contributors in Great Britain in 1938, 293,200 persons or about 35 per cent of the total voluntary contributors were not entitled to medical benefits.

DEPOSIT CONTRIBUTORS

Among the persons described above, those who did not wish to join an Approved Society were insured under a special scheme, administered by the Ministry of Health and the Insurance Committees. The contributions of such persons were carried to individual accounts in a Deposit Contributors' Fund, and the cash benefits (but not the medical benefits) of the contributor ceased as soon as the balance to his credit was exhausted. Also, persons who were unable to join by reason of their health were admitted to a special Insurance Section and entitled to the ordinary benefits of the Act, but not the additional benefits. Deposit contributors, including those juvenile contributors and voluntary contributors who were enrolled under this scheme, numbered 305,000 in Great Britain in 1938, representing only 1.4 per cent of the total insured population.

As of July, 1947, in anticipation of the new program, all new entrants to the health insurance scheme automatically became members of the Deposit Contributors' Fund.

SERVICE PERSONNEL

Service personnel had their "employer" contributions paid on their behalf by the respective Armed Service Councils. For those servicemen who were members of Approved Societies, contributions deducted from pay (at the reduced rate of 3d. a week), and "employer" contributions were forwarded to these Societies. The Maternity Benefit, the only benefit for which service personnel could make claim, was paid by the respective Societies. Those servicemen who were not members were covered by a special Army, Navy and Air Force Insurance Fund, under the Ministry of Health. This Fund also bore the expense of health insurance benefits for discharged men who, for reasons of ill health, were unable to obtain membership in Approved Societies. It covered an estimated 136,000 servicemen in 1938.

COVERAGE LIMITATIONS

The major groups not covered, but within the maximum income limit of £420, included the wives and children of insured workers and voluntary contributors, small shop-keepers, independent workers(1) (since the service was restricted to persons in gainful employment) and their dependents, elderly dependents of insured workers, and persons over 65 years not holding prior insurance status under the Act, including those over 70 years in receipt of non-contributory old age pensions.

(1) Colin Clark estimated there were in 1932, 1,030,000 independent workers earning less than £250 per annum.

The Royal Commission on Health Insurance of 1924-25 calculated that if coverage could have been extended to the dependents of insured persons, the number of persons eligible for medical benefits would have risen by 16 million.

At no time did the health insurance program cover more than 52 per cent of the total population. In 1914, 13,689,200, or about 33 per cent of the total population, were said to have been eligible for medical benefits under the Act. The scope of coverage was progressively enlarged by the interlocking of the Widows', Orphans' and Old Age Contributory Pensions Act (1925) with the health insurance scheme, (whereby all those insured under national health insurance became insurable under the Pensions Act and combined contributions became payable in respect of both schemes) and by other provisions such as those affecting insured unemployed persons in 1936 and the extension of insurance to juvenile contributors in 1938. The percentage of the population covered by the scheme remained quite steady at about 40 per cent from 1928 to 1935, then increased to 46 per cent in 1938 following these provisions. The expansion in industrial activity during the war years, together with the entrance of married women into insurable employment, and the increase in maximum income allowable from £250 to £420 per year in 1942, served to increase the coverage of the scheme to a peak of 52 per cent in 1943. By 1947, the last full year of operation, 23,009,774 persons, or about 48 per cent of the total civilian population of

Great Britain were estimated to have been entitled to medical benefit under the Act.(1)

Table I shows the composition of the total insured group, under broad headings. It will be noted that in 1946 the great majority of insured persons were covered through their membership in Approved Societies. This was the case throughout the lifetime of the scheme, although the proportion of Approved Society members in the insurance system decreased to some extent after the initial year. Deposit contributors made up a small percentage of the total insured population. From 1914 until the war years, there was a fairly continuous decline in this category which was particularly marked after 1926 with respect to male deposit contributors. Female deposit contributors, who numbered 96,800 in 1914, increased fairly steadily after 1925 to a total of 613,000 in 1947.

---

(1) See Appendix IV for total numbers of insured persons 1928-1947.

Table I - ESTIMATED NUMBER AND PERCENTAGE DISTRIBUTION OF PERSONS ENTITLED TO BENEFITS UNDER NATIONAL HEALTH INSURANCE, GREAT BRITAIN, BY TYPE OF MEMBERSHIP, DECEMBER 31, 1946

Type of Membership	Number			Per Cent of Total
	Men and Boys	Women and Girls	Total	
	000's	000's	000's	
Approved Society Members	13,257	7,879	21,136	86.3
Persons over 65 years(1)	1,508	742	2,250	9.2
Army, Navy and Air Force Fund	638	71	709	2.9
Deposit Contributors	151	228	379	1.6
Exempt Persons(2)	2	1	3	0.0
Total	15,556	8,921	24,477	100.0

Source: Report of the Ministry of National Insurance 1944-1949, (HMSO, London, 1950) p. 98; Cf. Appendix IV.

(1) See p. 57.
(2) See p. 31.

Summarized in Table II are the classes of insured persons covered by the scheme, by occupational category and by income limit. It should be noted that the income limits refer only to eligibility for insurance status, which does not necessarily entitle a person to the full benefits of the scheme.

Table II - MAXIMUM INCOME APPLICABLE TO INSURANCE ELIGIBILITY UNDER NATIONAL HEALTH INSURANCE, BY TYPE OF COVERAGE, GREAT BRITAIN, 1911, 1918, 1920, 1937 AND 1942

Type of Coverage	Maximum Limit for Insurance Eligibility				
	1911	1918	1920	1937	1942
Compulsory					
Manual Workers	No Limit	No Limit	No Limit	No Limit	No Limit
Non-Manual Workers	£160	£160	£250	£250	£420
Juveniles	N.A.	N.A.	N.A.	No Limit	No Limit
Voluntary					
Formerly Compulsory with:					
Five Years' Insurance	No Limit	N.A.	N.A.	N.A.	N.A.
Two Years' Insurance	N.A.	No Limit	No Limit	No Limit	No Limit
Persons Engaged in:					
Other Regular Occupations	£160	N.A.	N.A.	N.A.	N.A.
Excepted Employment					
Manual	No Limit	No Limit	No Limit	N.A.	N.A.
Non-Manual	£160	£160	£250	N.A.	N.A.

N.A. - Not Applicable.

Source: The National Insurance Act, 1911, and the National Health Insurance Act, 1936, as amended.

VI BENEFITS

STATUTORY BENEFITS

(1) Medical Benefits

(a) General Practitioner Services

Insured persons, but not their dependents, were entitled to free medical treatment and attendance immediately on payment of one contribution. The terms of service for insurance medical practitioners stated specifically that "all proper and necessary medical services, other than those involving the application of special skills and experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess, shall be provided." In short, the medical care provided was that of general practitioner service only. This service included office and home visits, if the patient's condition required it, with no limit placed on the number of medical service attendances a patient might demand of his own doctor. Treatment or attendance at confinement were excluded, but the practitioner was expected to provide pre-natal care for insured women. Voluntary contributors whose total income exceeded £420 were not entitled to medical benefits. As an indication of the relative significance of medical benefits under the scheme, it may be noted that they amounted in 1947 to 41 per cent of the total expenditure on benefits.

The Act entitled an insured person to select the medical practitioner of his choice, "subject to the consent of the practitioner so selected", and to transfer at will to

another practitioner at prescribed times. The patient's choice was of course limited by the number and distribution of insurance practitioners. More particularly, choice was limited by the fact that an insured person, to secure treatment under the Act, was required to select a doctor from the approved list of the area in which he resided, and that practitioners in any area could distribute insured persons amongst themselves if these persons had failed to make a selection or had been refused by the practitioner whom they had selected.

The insurance medical service was open to any qualified medical practitioner who had his name entered on the medical list of an Insurance Committee. Practitioners were given the right to choose or refuse patients but this right was restricted by the fact that the insurance practitioners in any area had to accept collective responsibility for all insured persons within that area. Furthermore, an insurance practitioner could not have more than 2,500 insured patients on his panel without the consent of the Ministry, nor more than 1,500 additional patients for each assistant.

The Ministry of Health at the time of the Royal Commission, (1924-25) made certain investigations into the proportion of persons on the lists of panel doctors; the evidence was that

35 percent of the total had lists of under 600
30 percent " " " " " " 600 - 1,199
21 percent " " " " " "1,200 - 1,999
14 percent " " " " " "2,000 - or more

In 1938, the average number of insured persons on a practitioner's list was about 1037; in all probability a relatively small percentage of panel doctors reached the maximum number (2,500). This suggests that, of the factors restricting a patient's choice of doctor, the limit placed on the number of insured patients a practitioner might accept was less significant than other considerations such as the comparative distribution of insurance practitioners and insured population.

Although practitioners were expected to keep records "in such form as the Minister may from time to time determine" for clinical, administrative, and statistical purposes, there is evidence(1) that this obligation presented difficulties to doctors in busy practices, and the records of attendances and of certificates issued were not sufficiently accurate to be used statistically. However, the Chief Medical Officer of the Ministry of Health has estimated that in each year 8,000,000 insured persons, or 50.4 per cent of persons eligible for medical benefits in England and Wales, sought medical advice and over 50,000,000 attendances were given by the doctors.(2)

(b) Drugs and Pharmaceutical Services

Medical treatment and attendance benefits included "the provision of proper and sufficient medicines, (including prescribed chemical re-agents) and of the prescribed medical and surgical appliances".(3) "One of the fundamental

(1) Report of the Ministry of Health for the year ended 31st March 1949, Cmd. 7910, (HMSO, London, 1950), p. 139
(2) Annual Report of the Chief Medical Officer of the Ministry of Health for the year 1935, On the State of the Public Health, (HMSO, London, 1936), p. 72.
(3) National Health Insurance Act, 1936, Part XII, Sec.226 (1).

principles in the National Health Insurance scheme was that prescribing and dispensing of drugs were required to be separated, dispensing being done by pharmacists."(1) There were three exceptions in this regard. The practitioner himself was required to supply and not merely to prescribe (a) those drugs and supplies which are necessarily or ordinarily administered by a practitioner in person, (b) all drugs and supplies in rural districts where pharmacists were not available, (c) in all districts, drugs, etc., which were required for minimum use where pharmacists were closed, or in cases of emergency.

A memorandum from the Ministry of Health dated December 1946, commenting on the continuous increase in the cost of prescribing, noted that rising cost presented itself in two aspects (a) the difference observed between the prescribing costs of individual practitioners within an area, and (b) the wide differences between the average prescribing costs in different areas of the country. The memorandum concluded that some of the area cost differences could be attributed to factors under the control of practitioners, the main factor being the number of prescriptions issued to each person treated.

As an indication of the volume of prescriptions insurance practitioners were called upon to make, we note that in England in 1938, 65,416,000 prescriptions were issued, or an average of 4.5 prescriptions per insured person,

---

(1) R.W. Harris, op.cit. p. 159.

(67,887,000 and 4.0 in 1947). In Wales, 2,840.000 official prescriptions were dispensed by chemists in 1938, or 4 per insured person. In contrast, total prescriptions issued in 1938 in Scotland were 3,003,421, or an average of 1.6 prescriptions per insured person entitled to receive drugs through chemists, (3,640,384 and 1.7 in 1947).

Prescribing practitioners in Scotland issued an average of 1,741 prescriptions each in 1937, whereas insurance practitioners in England issued an average of 4,100 prescriptions each in the same year. This figure would be much closer to 4,400 if we were to exclude rural practitioners who supplied drugs themselves, and to consider only prescribing practitioners. The contrast serves to illustrate the much greater reliance on drugs in the practice of medicine in England.

In theory, no definite restriction was imposed on the practitioner as regards prescribing. By his terms of service the practitioner was required to order such drugs and prescribed supplies as were requisite for the treatment of any patient. While the criterion was not cost, but necessity, the total sum available under the Drug Fund acted as a limitation on prescribing. The Minister of Health had power to adjudicate on "excessive" prescribing in single cases of treatment, but not on average costs of a practitioner over a span of time.

(2) Sickness Benefits

In addition to medical service benefits, financial assistance was provided to certain categories of insured persons during periods of incapacity due to illness. Exempt persons,

juvenile contributors, and persons over 65 years (or women over 60 years), were not entitled to any of the cash benefits; servicemen were eligible only for maternity benefits. Sickness (and disablement) benefits were paid at flat rates, with no additional rates for dependents.

Such benefits were dependent upon an insured person's contributory record. Unlike medical benefits they did not begin on the first day, but rather on the fourth day of disability. The ordinary rates of sickness benefit were 18s. a week for men, 13s. for married women, and 15s. a week for unmarried women and widows.(1) It is interesting to note that an industrial worker's sickness benefit amounted to 22 per cent of his average weekly wage in 1938, 16 per cent in 1942, and 14 per cent in 1947, as compared with the Workmen's Compensation benefit of from 50 to 67 per cent of his weekly wage.

Sickness benefits were payable after 104 weeks of employment in an insurable occupation and 104 weeks of contributions, and continued for as long as the incapacity existed, up to a maximum of 26 weeks in any twelve-month period. Benefits were payable at the reduced rates of 12s. a week for men,

(1) Married women referred to here are those who are employed and insured. Prior to 1942, the rates of sickness benefit in each case had been 3s. less than the above figures. These lower rates had continued unchanged since 1920, with the exception that, until 1933, married women had received the same weekly benefit (12s.) as single women. Prior to 1929, married women in the special Class K category had been paid sickness benefits at the reduced rate of 7½s. a week.

and 10s. 6d. a week for single and married women and widows when only 26 weeks of contributions had been made. Sickness benefits could be reduced on account of arrears (except when such arrears were due to involuntary unemployment on the part of the insured worker - see page 60) and ceased at 65 years of age. This type of benefit was supplemented by those Approved Societies in a position to do so.(1)

To obtain sickness benefits, a sick person had to secure from an insurance practitioner an initial medical certificate of incapacity for work. Intermediate certificates were given at weekly intervals, except in cases of prolonged incapacity, and the insurance practitioner was required to notify the Approved Society by means of a final certificate, when he considered the patient capable of work.

As an indication of the extent of claims for sickness benefit, it may be noted that in Scotland in 1938, 417,067 initial certificates of incapacity were issued, or 227 certificates per 1,000 eligible members of Approved Societies. The average duration of certified incapacity for work during the year was 14.08 days per member. The corresponding figures for England and Wales are not obtainable.

Sickness benefit claims were inspected and controlled through sick visitors employed by Approved Societies, usually on a part-time basis. In 1922 the Ministry of Health instituted a system of Regional Medical Officers to decide on

---

(1) See below p. 55.

questions of employability. In 1931 the whole problem of certification for employment came under review; the Ministry carried out a critical study and reported that there was a marked and continuous rise in sickness benefits, and that this was due mainly to the increase in the number of persons who received sickness or disablement benefit although not incapable of work.(1) Sickness benefits in 1947 represented 31.2 per cent of the total expenditure on benefits.

(3) Disablement Benefits

Disablement cash benefits, following an exhaustion of 26 weeks of sickness benefits, were paid for as long as the incapacity continued, but ceased at age 65 (60 years in the case of a woman). The weekly rates of disablement benefit amounted to 10s. 6d. for men, 9s. for single women and 8s. for married women. Originally these long-term disability benefits had amounted to 5s. weekly, regardless of sex, with an increase to 7s. in the period 1920 to 1933. But in the latter year a distinction was made between males and females when it was shown that women, especially married women, were making heavier claims on their Societies for disablement benefits than men. The rates for single women were reduced at that time to 6s., and for married women to 5s., remaining unchanged until 1942.

---

(1) National Health Insurance Joint Committee, Memorandum on Certification of Incapacity for Work, Giving the Results of Recent Investigations as to the Causes of Increase of Claims to Sickness and Disablement Benefit, Memo. 329/I.C. (London: HMSO, May 1931), p.16.

Insofar as the weekly compensation or damages awarded under the Workmen's Compensation Acts, the Employer's Liability Act or at common law were less than the above-mentioned sickness and disablement benefit rates, insured persons receiving such compensation or damages were entitled to such part only of the sickness or disablement benefit as, together with the weekly compensation, would be equal to the benefit in question. The general rule was that the injured worker received sickness benefit under the Workmen's Compensation legislation and medical benefit under the National Health Insurance Act.

These benefits accounted for 16.7 per cent of the total expenditure on benefits in 1947.

(4) Maternity Benefits

The Act did not provide for any medical treatment during confinement. However, a lump sum payment of £2(1) was made upon a claim filed within six months following confinement of the wife of an insured man or of a woman who was herself insured. A married woman who was insured received two maternity benefits (£4), one from her husband's insurance, and one from her own. If her husband was not insured, or not eligible for maternity benefit, two benefits were paid from her own insurance. Married women who were employed contributors were required to abstain from work for a period of four

---

(1) Prior to 1920 a payment of £1½ was made.

weeks following confinement, during which time they were not entitled to sickness benefit. An Approved Society was authorized to increase the lump sum maternity benefits for both men and women if the Society was found to have disposable surpluses.

No insured person was entitled to maternity benefit until he had paid forty-two weekly contributions, and had been credited with twenty-six contributions in the previous year.

For the last twenty years of the scheme, maternity benefits in Great Britain represented only about 5 per cent of the total expenditure on all benefits.

ADDITIONAL BENEFITS

In addition to statutory cash benefits, an Approved Society was authorized to provide extra benefits if quinquennial valuation showed it to have a "disposable surplus" of income over expenditure, in the form either of increases in the normal cash sickness, disablement or maternity benefits, or of payments towards the cost of certain specified types of treatment. These additional benefits played a most important and much disputed part in the British scheme. The additional benefit provision was an attempt to widen the scope of the limited statutory benefits by ad hoc arrangements with the various Approved Societies.

There was considerable variation in the ability of the Societies to provide benefits, in the selection of additional benefits, and in the quality of the same additional

benefits when provided by different Approved Societies. Each Society made its own decision as to which additional benefits it would offer its members, subject to the approval of the Minister.

The Government Actuary's report on the Fifth Valuation of Approved Societies stated that of the total membership of all types of Approved Societies in 1939, numbering 18,168,118 (12,057,040 men and 6,111,078 women), about 88 per cent of the men and 81 per cent[1] of the women were members of Societies with schemes of additional benefits.[2]

(1) Treatment Benefits

Treatment additional benefits in the form of cash, not service, were provided to the members of Societies with schemes of additional benefits, after 2½ years of membership. At least 84 per cent of the male members and 61 per cent of the female members of such Societies in the United Kingdom were entitled to some treatment additional benefits in 1943.

Certain forms of treatment, on which the Approved Societies could meet the cost, either in whole or in part, were specified in the Act. These included:

---

(1) This figure would be 64 per cent if one large fund providing a scheme of additional benefits of only nominal value is excluded.

(2) About 2½ million persons were members of Approved Societies without schemes of additional benefits. These figures are for the whole United Kingdom. Cf. Government Actuary, Fifth Valuation of the Assets and Liabilities of Approved Societies, Cmd. 6455, (HMSO, London, 1943) pp. 6, 10.

(i) Medical or surgical advice or treatment beyond the scope of medical benefits

(ii) Dental treatment

(iii) Hospital treatment

(iv) Convalescent home treatment

(v) Maintenance of convalescent homes

(vi) Medical and surgical appliances

(vii) Ophthalmic treatment

(viii) Nursing care

(ix) Charitable institution treatment

The member had to furnish written applications for all benefits except numbers (iii), (v), and possibly (viii), and medical certificates for all but (ii), (iii), and (v). Before commencing treatment he was required to await the Society's written authorization of his application.

Dental and ophthalmic benefits were the most widespread forms of treatment additional benefits offered by Approved Societies. Specialist advice was seldom offered, except where it was included under hospital services. The number of members of Approved Societies who were eligible for the five major types of treatment benefits in Great Britain in 1938 is shown in Table III. It will be noted that whereas 72 per cent of all members were eligible for dental treatment in 1938, and 62 per cent were entitled to ophthalmic benefits, only 10 per cent were eligible for hospital care.

Table III - NUMBER OF MEMBERS OF APPROVED SOCIETIES ENTITLED TO TREATMENT ADDITIONAL BENEFITS AND PER CENT OF TOTAL MEMBERSHIP, BY TYPE OF BENEFIT AND NATIONAL AREA, NATIONAL HEALTH INSURANCE, DECEMBER 31, 1938.

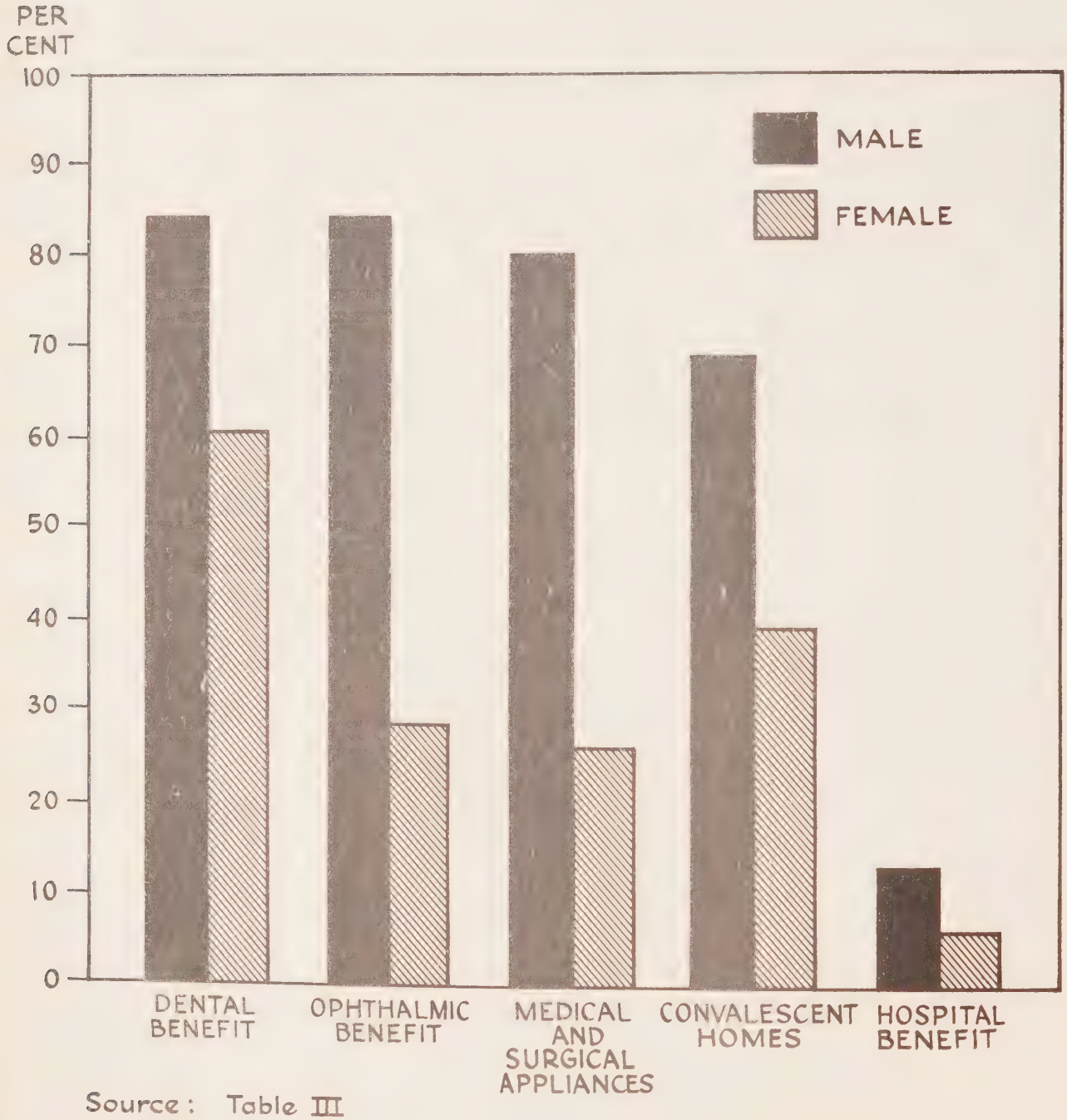
Type of Benefit	Approximate Membership Covered				Per Cent of Total Approved Society Membership
	England	Wales	Scotland	Gt.Britain	
Dental	11,786,000	526,465	1,243,356	13,555,821	71.6
Medical & Surgical Appliances	11,348,000	512,781	1,089,122	12,949,903	68.4
Convalescent Homes	10,796,000	446,329	659,238	11,901,567	62.9
Ophthalmic	10,050,000	472,518	1,250,580	11,773,198	62.2
Hospital	1,606,000	57,463	221,426	1,884,889	10.0

Source: Twentieth Annual Report of the Ministry of Health, (HMSO, London, 1939) pp. 149, 212; Tenth Annual Report of the Department of Health for Scotland, (HMSO, Edinburgh, 1939), p. 238.

The disparity in benefits extended to men and women under additional benefit schemes in operation in the United Kingdom in April 1943 is revealed by the numbers of persons, shown in Table IV and Chart 1, who were entitled to each benefit as a percentage of total membership. (It should be pointed out that ophthalmic treatment was excluded from the treatment additional benefit schemes of several of the largest Women's Funds.)

CHART 1

PERCENTAGE OF MEMBERS OF APPROVED SOCIETIES ENTITLED TO MAJOR TREATMENT ADDITIONAL BENEFITS, BY SEX, AND TYPE OF BENEFIT, NATIONAL HEALTH INSURANCE, UNITED KINGDOM. 1943



Source: Table III

Table IV - PERCENTAGE OF TOTAL APPROVED SOCIETY MEMBERSHIP ENTITLED TO EACH TYPE OF TREATMENT ADDITIONAL BENEFIT, BY BENEFIT AND SEX, UNITED KINGDOM, 1943.

Type of Benefit	Men	Women	Men and Women
Dental Benefit	84	61	76
Ophthalmic Benefit	84	28	65
Medical and Surgical Appliances	80	26	62
Convalescent Homes	69	39	59
Hospital Benefit	13	6	10

Source: Government Actuary, Fifth Valuation of the Assets and Liabilities of Approved Societies, Cmd. 6455, (London: HMSO, 1943), p. 12.

(a) Dental Benefit

Ordinarily Societies paid not less than 50 per cent of the cost of dental treatment although as of 1946 this could be reduced to 40 per cent with the approval of the Minister. They were not allowed to pay less than 10s., or the full amount if less than 10s.(1) A member of an Approved Society who wished to claim dental benefit first had to apply to his Society, which sent him a "Dental Letter" which he took to the dentist of his choice. The dentist gave on the Dental Letter a description of the work he thought necessary, and the Letter was returned to the Society. If the Society hesitated to accept the dentist's estimate, it might refer the question to a Regional Dental Officer of the Ministry. In 1927, the Ministry of Health made available the services of six full-time Regional Dental Officers to advise both Approved Societies

(1) In 1944 this limit was raised to 12s. 6d., and in 1946 to 15s., exclusive of fees for examination.

and dentists on dental treatment matters arising in connection with dental treatment proposed and completed for insured persons.

Precise data on the number of insured persons receiving dental treatment benefits are not available, but it has been estimated that during the prewar years this number was between 700,000 and 800,000 annually in England and Wales, or 6 per cent of those eligible for such benefits. The corresponding figure for Scotland was 7 per cent.

(b) Ophthalmic Benefit

Insured persons entitled to ophthalmic benefits could go directly to opticians for sight-testing and prescription of spectacles, but had to be seen by their own insurance doctors before they could receive ophthalmic treatment. The National Ophthalmic Treatment Board was set up in 1928 to provide the services of an ophthalmic surgeon at a fee of 10s. 6d. per examination to all compulsorily insured persons and their dependents, whether or not they were entitled to ophthalmic benefit, to all voluntary contributors entitled to such benefit, and to the general public with incomes below £250 a year. Those Societies providing ophthalmic benefits were required to pay a minimum of 5s. (7s. 6d. in 1945) toward the cost of optical appliances.

(c) Hospital, Specialist, Consultant Services

No hospital, specialist or consultant services were provided as normal medical benefit services under the Act.

Among additional benefits actually extended by Approved Societies, specialist treatment was limited to the dental and ophthalmic services noted above. Some hospital treatment was given by certain Approved Societies under their additional benefit schemes, but expenditure on hospital benefits in 1947 amounted to only 1.1 per cent of the total expenditure on treatment additional benefits. (See Appendix VIII.)

The approximate membership insured for hospital benefits under Approved Societies, was 1,884,889 in 1938, or 10 per cent of the total Approved Society membership. (See Table III). This figure may be compared with a prewar coverage of about 10 million persons under private voluntary contributory hospital insurance. Thus 25 per cent of the total population had some type of hospital insurance coverage.

(2) Cash Benefits

Concerning the statutory rates the Royal Commission on Workmen's Compensation (1940) remarked: "The health insurance scheme was based on a pre-existing voluntary system and it was not the intention of Parliament that the rate of benefit should be related either to wages the man had received or to his necessities. It was to provide a minimum benefit..." Additional cash benefits then were authorized to supplement the "minimum" statutory benefits, when the Approved Societies were in a position to do so.

Members of Approved Societies did not become eligible for cash additional benefits until commencement of the

fifth calendar year following the year of admission to the Society.

Roughly three-quarters of the male members of Approved Societies offering additional benefits, and one-third of the female members, were eligible for cash additional benefits. The most common rates[1] of payment were 3s. a week for men and 1s. for women, in addition to their statutory sickness and disablement benefits. That is, a male member temporarily incapacitated through illness might have received the basic 18s. a week sickness benefit (assuming he had full contribution and insurance status) plus 3s. from his Society. Having in mind the lower statutory sickness rates for both unmarried (15s.) and married women (13s.), we note that the effect of the cash additional benefits that were available through certain Societies was to increase the disparity between men and women.

GENERAL ELIGIBILITY QUALIFICATIONS

(1) Medical Benefits

As previously mentioned medical benefits were available from the date of a person's entry into insurable employment. Voluntary contributors (paying both the employer and the employee weekly contribution rate) were entitled to receive medical benefits if their total income from all sources

(1) Forty-seven per cent of the male members of Approved Societies were entitled to 3s. or more weekly, and 26 per cent of the female members could get at least 1s. in additional sickness benefits per week. In the case of 13 per cent of the male members and 2 per cent of the female members, the additional benefits amounted to 5s. or more weekly.

did not exceed £420 per year. If a person was still insured on attaining the age of 65 years, his medical benefit continued without further contributions.(1)

(2) Sickness Benefits

Unlike medical benefits, cash benefits during illness were based on a minimum period of insurance coverage and a minimum number of contributions. In order to qualify for receipt of full sickness benefits during a benefit year, (January to December), an insured person must have been insured for 104 weeks, and must have paid 104 contributions since entry or last re-entry into insurance, and as well, he must have been credited with 50 contributions for the contribution year terminating at the end of the previous June. Twenty-six weeks of insurance and 26 weeks of contributions allowed insured persons to receive sickness benefits at a reduced rate. As previously mentioned, the duration of sickness benefits was 26 weeks and in counting the 26 weeks, periods of incapacitation, separated by intervals of less than 12 months, were linked together and treated as if they formed a single illness. Sickness benefits began only on the fourth day of sickness.

The income restriction on voluntary contributors did not apply to sickness or disablement benefits.

---

(1) After 1938, however, employers were required to make contributions on behalf of their employees aged 65 years or over.

If a person ceased to be insured[1] and subsequently returned to insurable employment, he was treated as though he were becoming insured for the first time.

(3) Disablement Benefits

Eligibility provisions for disablement benefits were the same as those required for sickness benefits, except that disablement benefits were not payable until 104 contributions had been made and 26 weeks of sickness benefits at the full rate had been exhausted.

(4) Class K Benefits

Married women, who were transferred to a special class of insurance on ceasing employment within twelve months of marriage, were entitled to the following limited benefits:

(i) sickness benefit at the normal rate[2] for a maximum period of six weeks during a period of twelve months from the date of unemployment;

(ii) a single maternity benefit of £2, regardless of arrears, in respect of the first confinement after the date of unemployment and within two years from the date of marriage;

(iii) medical benefit for a year from the end of the half-year in which the date of unemployment fell; and

(iv) any additional benefits provided by the Approved Societies to which they belonged.

---

(1) See free insurance period, No. (5) below.
(2) This benefit was paid at the reduced rate of 7s. 6d. a week until January, 1929.

(5) Free Insurance Period

A "free insurance period" averaging about 21 months was granted to all members of Approved Societies except "Class K women" on ceasing insurable employment, provided they had been insurably employed for at least eight weeks between such free periods. Such a period continued until June 30th or December 31st whichever came next before the end of a period of two years after ceasing insurable employment. During a free insurance period, all types of benefits were available. At the end of such a period all benefits ceased unless a person resumed employment, or became a voluntary contributor or was eligible for "extended insurance". If an employed contributor returned to insurable employment, or became a voluntary contributor within the free insurance period, he might be required to pay arrears for the period since he was last insurably employed, unless he had been genuinely unemployed throughout this period.

(6) Unemployment and the Extended Insurance Period

The "free insurance" described above was extended by a further period of one year to an unemployed person provided that he had been continuously insured as an employed contributor for the ten previous years, and was incapable of working or of finding work during all but 12 weeks of the free insurance period. Following this extended insurance period a person continued in insurance from year to year provided he remained "genuinely" unemployed.

During periods of extended insurance, eligible persons retained title to medical and maternity benefits and to such additional treatment benefits as were provided by their Societies, but not to sickness and disablement benefits. Upon resumption of insurable employment during such a period, and the payment of 26 weekly contributions, a person became re-entitled to the full benefits of the Act.

(7) Arrears

Persons falling into arrears, other than those "deemed to have paid contributions" for weeks of sickness or genuine unemployment, were allowed to make a lump sum payment in cancellation of arrears and so to become eligible for medical and other benefits during the following year. During 1934 and 1935, however, even genuinely unemployed persons were required to redeem half their arrears in order to qualify for the full benefits of the Act.

VII FINANCES

SUMMARY OF REVENUE AND EXPENDITURES

Payments for all medical and cash benefits provided by the National Health Insurance Act were made from a special Fund established by the Act, called the National Health Insurance Fund.

The Fund had two major sources of revenue: the health insurance contributions of employees and employers, and grants from the National Exchequer. The contribution rate was set so as to meet the costs to the Fund of all the benefits expected to be drawn by a person entering insurance at age 16 years, throughout his life. The government grants were set so as to provide amounts roughly equivalent to the contributions, plus interest, that would have been received from persons entering insurance at ages 17 to 65 years had they entered at 16 years. With a total expenditure in 1938 of £40 million, it will be seen from Table V that the total receipts from contributions and exchequer grants of £37 million were insufficient by themselves to meet the costs of benefits and administration. Interest on the investments(1) of the National Health Insurance Fund, amounting to approximately 15 per cent of the total receipts, made up the balance of the Fund's income. If the

---

(1) Sums not invested by the Societies, or by the Minister on their behalf, were invested by the National Debt Commissioners in securities authorized as investments for Savings Banks funds, giving preference to loans under the Housing Act, 1936.

assumptions regarding the sickness experience[1] and the age distribution of the insured population were valid, then the Fund could be expected to remain solvent. This actuarial approach to financing the scheme was consistent with the emphasis it placed on cash sickness benefits.

Table V - AMOUNT AND PERCENTAGE DISTRIBUTION OF RECEIPTS AND EXPENDITURE OF THE NATIONAL HEALTH INSURANCE FUND, GREAT BRITAIN, 1938 and 1947

Item	1938		1947	
	Amount	Per Cent	Amount	Per Cent
	£ 000's		£ 000's	
Receipts				
Contributions	29,879	67.5	39,010	63.0
Exchequer Grants	7,506	17.0	15,162	24.5
Interest, etc.	6,859	15.5	7,718	12.5
Total	44,244	100.0	61,890	100.0
Expenditure				
Benefits	33,972	85.0	50,860	84.9
Administration	5,988	15.0	9,062	15.1
Total	39,960	100.0	59,922	100.0

Source: See Appendix V, n.

These expenditures were made in respect of 21,129,000 insured persons in 1938, or 23,948,000 in 1947. They are thus equivalent to an expenditure of 37.8 shillings for every person covered in 1938, or 50 shillings per capita in 1947, representing the low and the high during the last twenty years

(1) Including the assumption that the average rate of one week of sickness per member per year could be applied to all Societies generally, without regard to the sickness experience of individual Societies which tended to vary with the occupational status of their members.

of the scheme. The prewar average per capita expenditure, as indicated in Appendix IX, was 40.6 shillings. The corresponding per capita receipts in the same two years amounted to 41.8 shillings and 51.7 shillings, while the prewar average was 42.7 shillings.

REVENUE

(1) Contributions

With a few exceptions, insured persons paid flat-rate contributions to the National Health Insurance Fund, varying not with the income, the age, nor the employment, but only with the sex of the contributor. After the last increase in rates in 1942, the normal weekly contributions were 11d. for men and 10½d. for women, of which the employer paid 5½d. in each case; voluntary contributors paid both the employer and the employee share. Exceptions to this principle of a uniform rate for all contributors were made in the cases of the very young and the very old, and of those ineligible for certain benefits. Juvenile contributors between the ages of 14 and 16, and their employers, each paid 2d. weekly into the Fund; employed persons continuing in employment after the age of 65 (60 in the case of women) ceased to pay contributions, but their employers continued to pay 5½d. weekly on their behalf.(1) In cases where the employee earned 3s. a day or less the employer paid the full contribution. Contributions of voluntary contributors

---

(1) After January 3, 1938. See pp. 13, 14.

earning more than £420 annually, and, therefore, ineligible for medical benefit, were reduced by 3d. a week; contributions of employers on behalf of merchant seamen on foreign-going ships (who were not entitled to medical benefit while at sea), were reduced by 2½d. a week; and contributions on behalf of servicemen (who were entitled only to maternity benefits) were reduced to 3d. weekly, paid wholly by the "employer".

Joint contributions under the contributory pensions scheme and the health insurance scheme were paid by affixing a stamp (ordinarily purchased from a post office) to the contributor's card for every week of employment. In the case of a voluntary contributor, this action was performed by the contributor without regard to weekly employment. In the case of an employed contributor, the employer was responsible for paying the whole contribution, and in turn deducted from the employee's wages the latter's share.

Total receipts from contributions in 1938 were just under £30 million, or 68 per cent of all National Health Insurance Fund revenues. Over the whole period, contributions on the average amounted to 67 per cent of all revenues, varying from a low of 64.4 per cent in 1931 to a high of 68.5 per cent in 1934, and a wartime high of 68.9 per cent in 1943.

(2) Actuarial Basis of Contributions

The normal weekly rate of contribution was calculated on the basis of the expected sickness experience of a person entering the scheme at age 16. At the inception of the

scheme in 1911, the contribution rates for men and women were 7d. and 6d. respectively; these underwent increases in 1920 to meet the higher costs of services, and decreases in 1926 following the reduced allocation of contributions to reserves and contingency funds. With the exceptions noted above, chiefly that depending on sex, all insured persons between the ages of 16 and 65 paid the same uniform contribution rate - that estimated to be equivalent in value to the lifetime demands on the scheme of a person entering at age 16 years. In consequence, the contributions were not sufficient to cover the expected sickness experience of persons becoming insured at any age between 17 and 65. To provide for this deficiency, the State assumed responsibility for 2/9[1] (or ¼ in the case of women) of the total cost of benefits and their administration. At the same time, a Reserve Value was created and credited to the appropriate Society, for each person entering insurance after 16 years, equivalent to the amount, including interest, that would have accumulated had he been contributing to the Fund since the age of 16 years. These were only paper credits and had to be gradually redeemed out of the amounts deducted by the Minister, from each person's weekly contribution, for the sinking fund - originally amounting to 2/9 of a man's contribution or one and five-ninths pence, and one-quarter of a woman's contribution or one and a half pence. Out of this sinking fund, interest was paid to the Societies at three per

---

(1) Later reduced to 1/7 and 1/5.

cent on the Reserve Values still outstanding, the balance serving to reduce the Reserve Values credited to the Approved Societies.

The original rates of contribution and benefit were based upon an actuarial estimate of 1 week's sickness per member per annum, without regard to occupational or regional differences. In fact, it was soon found that some women's Societies had sickness rates varying from 0.58 to 3.15 weeks per member, per annum, while certain men's Societies varied between 0.68 and 1.3 weeks per member. It was obvious that some Societies would realize surpluses and be able to expand their benefits, while others would suffer deficits and have to curtail their benefits. Apparently the designers of the British program considered uniform contributions preferable to uniform benefits.

(3) Exchequer Grants

The National Exchequer paid into the National Health Insurance Fund out of general revenue a sum equal approximately to one-sixth of the total cost of benefits and administration under the Act. Before 1926 the State contributed to the Fund an amount equal to two-ninths(1) of the total cost of the benefits conferred by the Act and the administration of those benefits. Following the Royal Commission's recommendations, in January, 1926, the State's share was reduced to one-seventh in the case of men and one-fifth in the case of women, of the

(1) Before 1920 this fraction was $\frac{1}{4}$ in the case of women.

costs of benefits and administration. The whole cost of central administration was also borne by the Treasury. It is of interest to note that under the British scheme, the Treasury paid a fixed proportion of the costs of benefits, rather than a fixed proportion of the contributions to the Fund.

In 1938, Exchequer Grants amounted to £7½ million or 17 per cent of total receipts, which percentage was also the average for the prewar period; these grants had ranged between a high of 19.5 per cent of revenue in 1929 and a low of 15.9 per cent in 1934. It should be mentioned that, in the period 1913 to 1922, supplementary grants had increased the Treasury's share of the cost of medical benefits from the statutory 2/9 to 4/9 or 45 per cent of medical benefit expenditure. By 1947 Exchequer Grants had increased to 25 per cent of National Health Insurance Fund receipts, or just double the actual amount contributed in 1938, following the sharp increase in practitioners' capitation payments in 1946.

TOTAL EXPENDITURES

It was noted above(1) that 1938 expenditure on benefits and administration under the National Health Insurance Act in Great Britain was £40 million. The average expenditure in the prewar period had been slightly lower than this - £38.4 million - ranging from a low of £36 million in 1934 to highs

---

(1) Cf. also Appendix V.

of £40 million in 1929 and 1939. A sharp increase in expenditure occurred during the war, with costs reaching £50 million in 1943 and £60 million in 1947.

It is of interest to note that roughly 0.88 per cent of the net national income in 1938 (£4638 million) was spent on health insurance, whereas in 1947, with a rising national income, this proportion had dropped to 0.67 per cent. As may be determined from Appendix XI, health insurance costs amounted to 21 per cent of the total cost of all the social insurance programs, and 10 per cent(1) of the cost of all social services in the prewar period. Chart 2 shows the relative size of expenditures on health insurance as compared with expenditures on each of the other social services in the fiscal year 1938-39.

BENEFIT EXPENDITURES

Of the expenditures in any year out of the National Health Insurance Fund on statutory and additional benefits, cash benefits accounted for a prewar high of 62 per cent in 1929, and for a low of 55 per cent in 1938, or an average of 59 per cent in the intervening period.(2) Thus, average expenditure on treatment benefits during the period amounted to approximately 41 per cent of total benefit expenditures.

The total expenditure for the major classes of benefits in 1938 and 1947 is indicated in Table VI.

---

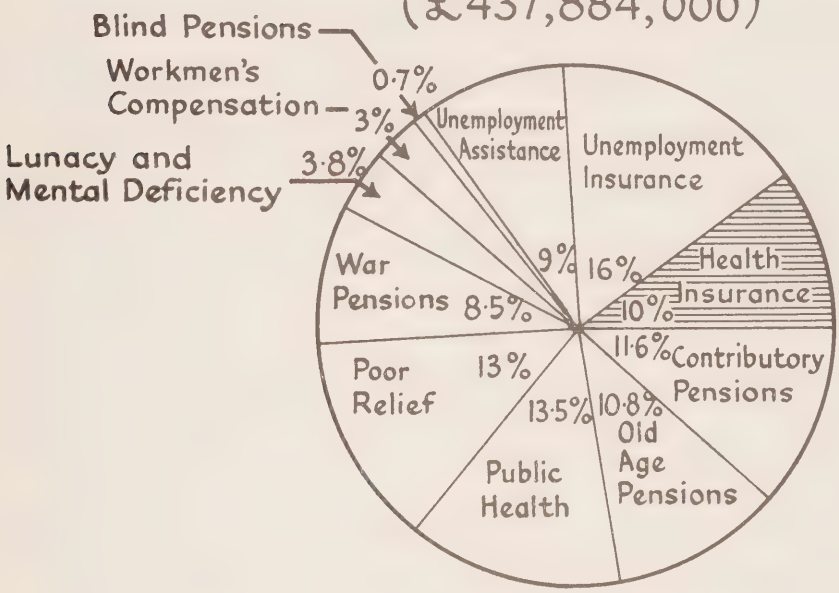
(1) Twelve per cent if public health costs are excluded.
(2) See Appendix VI.

CHART 2

PERCENTAGE DISTRIBUTION OF EXPENDITURES ON SOCIAL SERVICES AND ON HEALTH INSURANCE BENEFITS, GREAT BRITAIN, 1938.

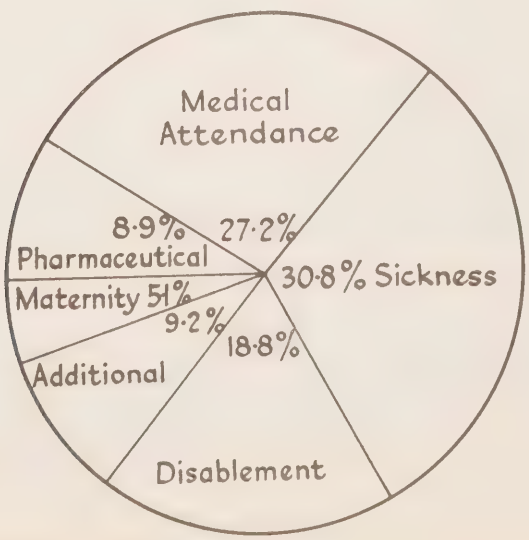
SOCIAL SERVICE EXPENDITURES, 1938-39

(£437,884,000)



HEALTH INSURANCE BENEFIT EXPENDITURES, 1938

(£33,972,000)



Source : Appendices VI, VII and XI

Table VI - AMOUNT AND PERCENTAGE DISTRIBUTION OF BENEFIT EXPENDITURE BY TYPE OF BENEFIT, NATIONAL HEALTH INSURANCE, GREAT BRITAIN, 1938 and 1947

Type of Benefit	1938		1947	
	Amount	Per Cent	Amount	Per Cent
	£000's		£000's	
Treatment Benefits	15,369	45.3	23,868	47.0
Statutory Medical(1)	12,259	36.1	21,045	41.4
Additional(2)	3,110	9.2	2,823	5.6
Cash Benefits	18,603	54.7	26,992	53.0
Sickness	10,475	30.8	15,871	31.2
Disablement	6,380	18.8	8,503	16.7
Maternity	1,748	5.1	2,618	5.1
Total	33,972	100.0	50,860	100.0

Source: Appendix VI.

(1) General Practitioner treatment and drugs.
(2) Cash indemnification for dental, ophthalmic, hospital, and other expenses.

(1) Treatment Benefits

It can be seen from Table VI that expenditure on treatment(1) benefits in 1938 amounted to £15 million, or 45 per cent of total benefit expenditures. By 1947, with the increase in capitation payments, this proportion had increased to 47 per cent, although absolute expenditure on additional benefits had actually decreased.

(a) Statutory Medical Benefits

Expenditure on medical benefits, including drugs, remained quite steady at £10 million between 1928 and 1935, ranging between a low of £9,970,000 in 1932 when a 10 per cent emergency reduction in practitioners' and chemists' remuneration

(1) Treatment additional benefits were in the nature of cash indemnification rather than direct services.

was imposed, and a high of £10,689,000 in 1931. In this same period, the cost of medical benefit varied from 30.0 per cent of total benefit costs in 1929 to 33.4 per cent in 1935. (See Appendix VI.)

With the repeal of the emergency reduction of fees order in 1935, the new agreements for the remuneration of chemists negotiated in 1936 and 1938, and the increase in practitioners' capitation fees in 1942, 1944, and 1946, expenditure on medical benefits rose considerably over this later period, from a low of £10,851,000 in 1936 to a high of £21,045,000 in 1947, as Table VII indicates. These expenditures represented 33.3 per cent and 41.4 per cent of the total cost of benefits in these years.

Table VII - EXPENDITURES ON STATUTORY MEDICAL BENEFITS, 1928-1947
(£000's)

1928 - 10,093	1933 - 10,165	1938 - 12,259	1943 - 13,822
1929 - 10,338	1934 - 10,071	1939 - 12,412	1944 - 14,723
1930 - 10,284	1935 - 10,386	1940 - 12,190	1945 - 15,090
1931 - 10,689	1936 - 10,851	1941 - 12,171	1946 - 18,441
1932 - 9,970	1937 - 11,368	1942 - 13,155	1947 - 21,045

Source: See Appendix V, n.

In 1938, 11.6 shillings were spent on medical benefits for every insured person,(1) including 2.7 shillings per

(1) See Appendix IX. This figure would be closer to 12 shillings per capita if only insured persons who were eligible to receive medical benefits were considered, that is, if such categories as service personnel and voluntary contributors receiving over £420 income were excluded.

capita on drugs. By 1947, these rates had increased to 17.6 shillings and 5 shillings respectively.

The chief items of which medical benefit consisted were medical attendance and pharmaceutical supplies(1) with practitioners' capitation payments accounting for roughly 73 per cent, and chemists' receipts 21 per cent of the total costs of medical benefits. The remaining expenditures included mileage payments to rural doctors, 3 per cent, and payments for drugs dispensed by practitioners, 2 per cent.

(b) Treatment Additional Benefits

Expenditure on additional benefits in the pre-war period was fairly stable at 9 per cent of the cost of total benefits, ranging from a low of 8.1 per cent in 1929 to a high of 10.2 per cent in 1930. This proportion gradually decreased during the war years to 5 per cent in 1942, where it remained. (See Appendix VI). Additional benefit costs varied from a high of £3,359,000 in 1930 to a low of £2,086,000 in 1941, with expenditures(2) on the chief types of additional benefits in 1939 and 1947 as indicated in Table VIII.

It will be noted that expenditure on hospital benefits was the lowest of all additional benefit expenditures, while that on dental benefits was consistently the highest, as shown in detail in Appendix VIII. One of the greatest limitations of the National Health Insurance scheme was that only

---

(1) See Appendix VII.
(2) See Appendix VIII for the detailed expenditures on various additional benefits between 1928 and 1947.

Table VIII - AMOUNT AND PERCENTAGE DISTRIBUTION OF TREATMENT ADDITIONAL BENEFIT EXPENDITURES, GREAT BRITAIN, 1939 AND 1947

Benefit	1939		1947	
	Amount	Per Cent	Amount	Per Cent
	(£000's)		(£000's)	
Dental	2,095	71.8	1,710	62.4
Ophthalmic	501	17.2	700	25.5
Appliances	121	4.1	170	6.2
Convalescent Homes	96	3.3	65	2.4
Hospital	40	1.4	30	1.1
Other	64	2.2	65	2.4
Total	2,917	100.0	2,740	100.0

Source: Report of the Ministry of National Insurance 1944-1949, (London: HMSO, 1950), p. 82.

2 million workers were eligible for hospital benefits by reason of their insurance. However, it must be remembered that ten million persons were enrolled in private hospitalization schemes, and that voluntary hospitals gave free or low-cost care to those who were unable to meet the full costs. Because only 10 per cent of all Approved Society members were entitled to hospital benefits, this limited expenditure of £40,000 in 1939 represented an outlay of 5.09 pence per eligible person. Table IX shows that per capita expenditures on additional benefits in 1939, particularly on hospital benefits, were considerably lower than the amounts set aside for such expenditures, indicating that full use was not made of those benefits that were available.

Table IX - PER CAPITA ALLOCATION AND EXPENDITURE ON TREATMENT ADDITIONAL BENEFITS, PER PERSON ELIGIBLE FOR EACH TYPE OF BENEFIT, 1939

(pence)

Type of Benefit	1939 Allocations	1939 Expenditures
Dental	42.7	37.1
Ophthalmic	13.0	10.2
Hospital	11.1	5.1
Appliances	3.5	2.2
Convalescent Homes	3.3	1.9

Source: Report of the Ministry of National Insurance 1944-1949, (London: HMSO, 1950), p. 82; cf. also Table III, p. 51.

(2) Cash Benefits

The chief types of cash benefit extended by the National Health Insurance Act were sickness, disablement, and maternity benefits, as described in Chapter VI.

(a) Sickness Benefits

Expenditure on sickness benefits varied from a low of £9.8 million in 1934 to a high of £19.1 million in 1944. As a proportion of total expenditure on all benefits, the cost of sickness benefits fluctuated from about 38 per cent in 1929 to less than 31 per cent in 1938, and to a high of 42.6 per cent in 1943(1) following the 1942 increase in rates of benefits. Of course it should be noted that, during the depression years, unemployed persons benefitting from a period of extended insurance were not entitled to sickness benefits. As indicated above, expenditure on sickness benefits in 1938 amounted to

(1) See Appendix VI.

£10,475,000, or 11.34 shillings for each person eligible for this type of benefit.

(b) Disablement Benefits

The proportion of total benefit expenditure allocated to disablement benefits remained fairly steady throughout this period, varying from 20.9 per cent in 1934 to 16.2 per cent in 1941. Expenditure on these long-term disability benefits reached a low of £6,077,000 in 1931, and a high of £8,619,000 in 1946. As already noted, 1938 expenditures amounted to £6,380,000, or 7.05 shillings for each person eligible for disablement benefits.

(c) Maternity Benefits

Expenditure on maternity benefits varied between 5.7 per cent of total benefit expenditures in 1931 and 4.3 per cent in 1945, reaching a low of £1,575,000 in 1933 and a high of £2,618,000 in 1947. Expenditure on this benefit in 1938 was £1,748,000 or 1.73 shillings for each person eligible for maternity benefits.

ADMINISTRATIVE EXPENDITURES

In 1938 and in 1947, expenditure on the administration of the health insurance program amounted to 15 per cent of total expenditures, or 5.6s. and 7.5s. per insured person respectively. Of these administration costs, the Approved Societies spent almost 75 per cent, the Central Administration 18 per cent, and the Insurance Committees only 8 per cent. In terms of the value of benefits handled by each administrative

agency, keeping in mind the fact that the Societies were responsible for payment of cash and additional benefits, and for checking on eligibility, incapacitation, and movement of members, while the Committees were responsible for maintaining doctors' panels, remunerating practitioners and pricing and paying pharmaceutical accounts, it is interesting to note that £1 was spent on administration of every £6 paid out by the Approved Societies and of every £26 handled by the Insurance Committees.

VIII METHODS AND RATES OF PAYMENT FOR PROFESSIONAL SERVICES

ALLOCATION OF REVENUES

All contributions and Exchequer Grants under the National Health Insurance Act were paid into the National Health Insurance Fund, which was under the control and supervision of the Minister. Out of this Fund the Minister paid 9.6d. from each weekly contribution (9.55d. in the case of women) into the Benefit Fund, and the remainder into the Sinking and Contingencies Funds.

Payments into the Benefit Fund were equivalent to 41.6 shillings (or 41.4) per person annually, and were augmented by the previously-mentioned Treasury grant of 1/7 (1/5) of the total cost of benefits and their administration.(1) Out of the Benefit Fund, 14½ shillings per person entitled to medical benefits were allotted annually to the Medical Benefit Fund after 1942,(2) and the remainder was credited to the account of the appropriate Approved Society, of which the person was a member, or to the Deposit Contributors' Fund. Additional Treasury grants were made at times to supplement these sums.

The Medical Benefit Fund in turn was distributed among certain subsidiary Funds as depicted in Chart 3. Amounts were paid each year into

(i) the Central Practitioners' Fund on a capitation basis,

---

(1) See p. 66.
(2) The original allotment of 6s. was increased to 9s. in 1912, to 9½s. in 1920, and to 13s. in 1927.

(ii) the Central Mileage Fund as determined by the Minister,

(iii) the Chemists' Central Fund on either a capitation or a cost-of-service basis,

(iv) the Practitioners' Drugs Accounts of the Insurance Committee on a cost basis,

(v) the Institutions' Funds of the Insurance Committees on a cost basis, and

(vi) the Administration Accounts of the Insurance Committees, not exceeding 6d. per person annually.

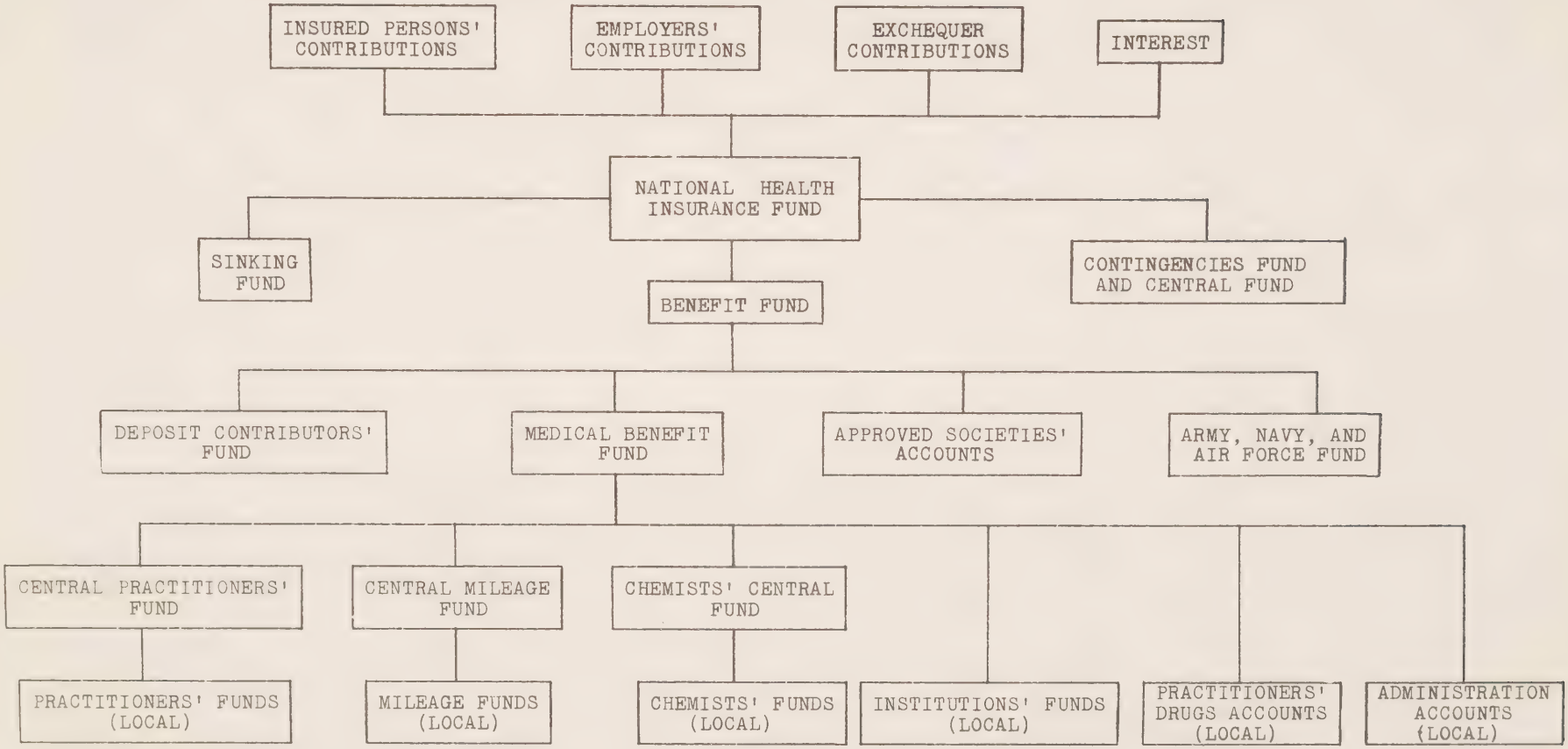
Each Approved Society was credited annually with the amounts remaining to its credit in the Benefit Fund in respect of each of its members. From these amounts were met the claims of its members for cash sickness, disablement, and maternity benefits. A Society whose members had below-average sickness experience would thus accumulate a considerable surplus in its account, which surplus would be available, after the next quinquennial valuation by the Government Actuary, for implementing those additional benefit programs approved by the Minister.

REMUNERATION OF PRACTITIONERS

From the commencement of medical benefits in 1913, there were two major sources of revenue for insurance practitioners - capitation payments for each insurance patient on the doctor's list (although at the outset a few areas chose to pay their doctors on an "attendance" rather than "capitation" basis),

CHART 3

FINANCIAL STRUCTURE OF NATIONAL HEALTH INSURANCE, GREAT BRITAIN, 1947



Source: National Health Insurance Act, 1936, and N.H.I. Medical Benefit Regulations, 1936.

and payments for drugs dispensed by practitioners. In addition, mileage payments were made to rural doctors in areas where communications were difficult, and small sums were set aside for providing telephones, automobiles, etc. in depressed or sparsely-settled areas. The percentage distribution of medical benefit expenditure on these items in the pre-1939 period is given in Appendix VII.

(1) The Capitation Method

The British scheme remunerated the insurance doctors on a capitation basis, each practitioner receiving a fixed sum for every insured person on his "panel". Actually, the Act permitted each Insurance Committee to determine the method of distribution to be followed in its area - on the basis of either the size of a practitioner's list, or the attendances or services he rendered to insured persons.(1) However, after 1928 all areas employed the capitation method. The sum paid into the Central Practitioner's Fund(2) was 9s. for each person eligible

---

(1) In addition, Institutions, whose insured employees were entitled to obtain treatment and drugs from them, were paid by the Insurance Committees, out of special "Institutions' Funds", either the cost of the treatment and drugs they supplied to these persons, or the amount that would have been spent by the Committees if these persons had been entitled to medical benefits in the ordinary way, whichever was less.

(2) The per capita sum to be paid each year into this Fund from the Medical Benefit Fund was agreed upon by the Minister and the British Medical Association; the allocation of this Fund among the various Insurance Committees was determined by the Minister, with the advice of the Medical Distribution Committee, on the basis of the number of residents in each area. The Central Practitioners' Fund amounted in 1938 to £8,846,000 or £465 per insurance practitioner, of whom there were about 19,000.

to receive practitioner treatment in the immediate prewar period; after certain small deductions for emergency and temporary resident treatment, this amount was distributed among practitioners according to the number of patients on their panels.

The original sum of 6 shillings per capita - based on the experience of contract practice before 1911 - was never accepted by the medical profession. The Treasury agreed to supplement(1) this amount by 2½s. and to require certain conditions as to the adequacy of service and medical certification. An additional 6d. was earmarked from sanatorium benefits on condition that practitioners would be responsible for the domiciliary treatment of tuberculosis patients. Of this total of 9s., 7s. was set aside for the practitioners, and 1½s. for the suppliers of drugs. The remaining 6d. (called the "floating sixpence") was paid to the chemists if the average per capita cost of drugs prescribed by the doctors amounted to 2s. However, if, by curtailing the prescriptions they issued, the doctors were able to reduce the average per capita cost of drugs dispensed in the area below 2s., the difference - up to a maximum of 6d. - was paid into the Practitioners' Fund and distributed among the doctors on a capitation basis.

In 1920 a new sum of 11s. per capita for practitioners was set by arbitration, and the floating sixpence abolished. At the same time mileage payments to rural doctors were greatly

---

(1) Treasury supplements were paid until 1927.

increased.(1) The rate was reduced to 9½s. per capita in 1922 as an economy measure, and was set by arbitration at 9s.(2) in 1924 at which amount it remained until 1942. However, from October 1931 until June 1934, and from June 1934 to June 1935 the panel practitioners accepted an emergency reduction in this rate, of 10 per cent and 5 per cent respectively. With the wartime increase in the cost of living, the payment was increased to 9s. 9d. in 1942 and to 10s. 6d. at the end of 1943. With the publication of the Spens Report recommendations, the rate was again increased to 15s. 6d. in 1946,(3) plus a 6d. supplement for each patient invalided out of the Armed Services.

(2) The Attendance Method

Although each Insurance Committee could choose its own method of remunerating doctors, by 1914 every area except Manchester and Salford had rejected the attendance or fee-for-service system as being unsatisfactory. These two areas adopted fee schedules showing the relative values of each type

(1) From £34,000 for England and Wales in 1911 to £300,000 in 1920. Between 1924 and 1938 the amount remained almost unchanged at £240,000. These payments, designed to augment the low incomes of rural practitioners and to compensate them for the expense and time involved in travelling, were based on the number of patients on each doctor's list and their proximity to his residence. The Minister, on the advice of the Medical Distribution Committee created a Central Mileage Fund every year, which was allocated to certain of the Insurance Committees in areas with special communication difficulties.

(2) This rate was set by a Court of Inquiry after the Minister had offered a rate of 8s. for 5 years, and 90 per cent of the insurance doctors had tendered their resignations.

(3) See pp.67,145 re increase in Exchequer Grants.

of practitioner service which were applied to the monthly records submitted by each doctor of the number of such services he had performed. The total pool for each area was distributed in proportion to the total of each doctor's accounts. This system was found to have certain disadvantages. Not only did it entail a complex accounting system, but it was said(1) that it penalized skilful practitioners who achieved success with a minimum number of attendances. In Manchester the average total value of services rendered by area doctors to each insured person treated during the month was determined from the accounts submitted. The account of any practitioner whose average monthly charges per patient treated exceeded this area average was reduced to the average scale, and distribution of the pool was then made on the basis of the accounts so reduced. In Salford the average number of attendances per person was determined, and the attendances of practitioners who exceeded the average were reduced to that average. However, since the inclusion of unnecessary attendances brought up the average, an arbitrary standard of the number of attendances the practitioner should make was set, based on the average attendances of certain practitioners over previous years. This required intimate knowledge of the practitioner and the type of work he did, and necessitated the close cooperation of individual practitioners and the Insurance Committee. These

---

(1) Cf. G.F. McCleary, National Health Insurance, (London, H.K. Lewis Co., 1932), p. 114.

complex systems were said to have so nearly approached the capitation system in operation, that the latter method of remuneration was adopted in Salford in 1927 and in Manchester in 1928.

The attendance or fee-for-service method was also used to remunerate dentists for their insurance work. A scale of fees for specific dental services that dentists might claim for treating insurance patients was negotiated by the Ministry and the Dental Board. These were set forth in the Dental Benefit Regulations of the National Health Insurance Act in 1938, undergoing upward revisions in 1944 and again in 1946.

(3) Payments for Drugs

At different times two methods were used under the British scheme for reimbursing doctors for the costs of emergency drugs, or those of necessity administered by the doctor. Originally a per capita payment of 1s. 3d. for every 100 persons on a practitioner's panel was made for this purpose. After 1933, doctors could order these drugs on the regular prescription forms, or claim repayment from the Insurance Committees. Rural practitioners who were required to supply drugs to their insured patients could elect to be paid either on the basis of the costs of these drugs as set forth in the Drug Tariff, or by a per capita payment for each patient entitled to receive such drugs. This payment increased from 2s. in 1912 to 2s. 3d. in 1927, 3s. 6d. in 1942, and 4s. 9d. in 1947. Dispensing doctors in Scotland were paid a capitation fee based on the

average cost per person of the medicines and supplies provided by chemists in that area in the previous year.

The Insurance Committees submitted returns to the Minister showing the amounts paid by them to practitioners for the provision of drugs and supplies to insured persons; in turn they were reimbursed for these expenses by amounts which were credited to their Practitioners' Drugs Account. Practitioners were paid £240,000 for this service in 1938, and £500,000 in 1947, of which only 4 per cent and 6 per cent respectively went to Scottish doctors.

(4) Practitioners' Incomes

Insurance practitioners, with an average panel in 1938 of 1037 persons, earned an average of £466.6 from their insurance practices, on the basis of a 9s. capitation fee, apart from their income from special mileage payments or from the provision of drugs. The median income of general practitioners from all sources was £1000 in the same year.

A survey of practitioners' incomes in 1936-1938 carried out for the Spens Committee on Practitioners' Remuneration[1] revealed that 33 per cent of general practitioners received net incomes of less than £800 annually in this period, 50 per cent received less than £1000, 77 per cent less than £1400, and 95 per cent less than £2000. It is interesting to compare these incomes with those received by dentists,

---

(1) Ministry of Health, Report of the Inter-Departmental Committee on Remuneration of General Practitioners, Cmd. 6810, (HMSO, London, 1946), Appendix II, pp. 17-31.

specialists and income taxpayers in 1938. A survey of dentists' incomes indicated that 57 per cent of dental practitioners received less than £800, while 95 per cent of the dentists received less than £2000. In the same year, 24 per cent of specialists received less than £1000, and 60 per cent of the specialists received less than £2000, in net annual incomes. As indicated in Appendix X, and as shown in Chart 4, in this same period, 75 per cent of all taxpayers earned net incomes of less than £400, and 91 per cent earned less than £800.

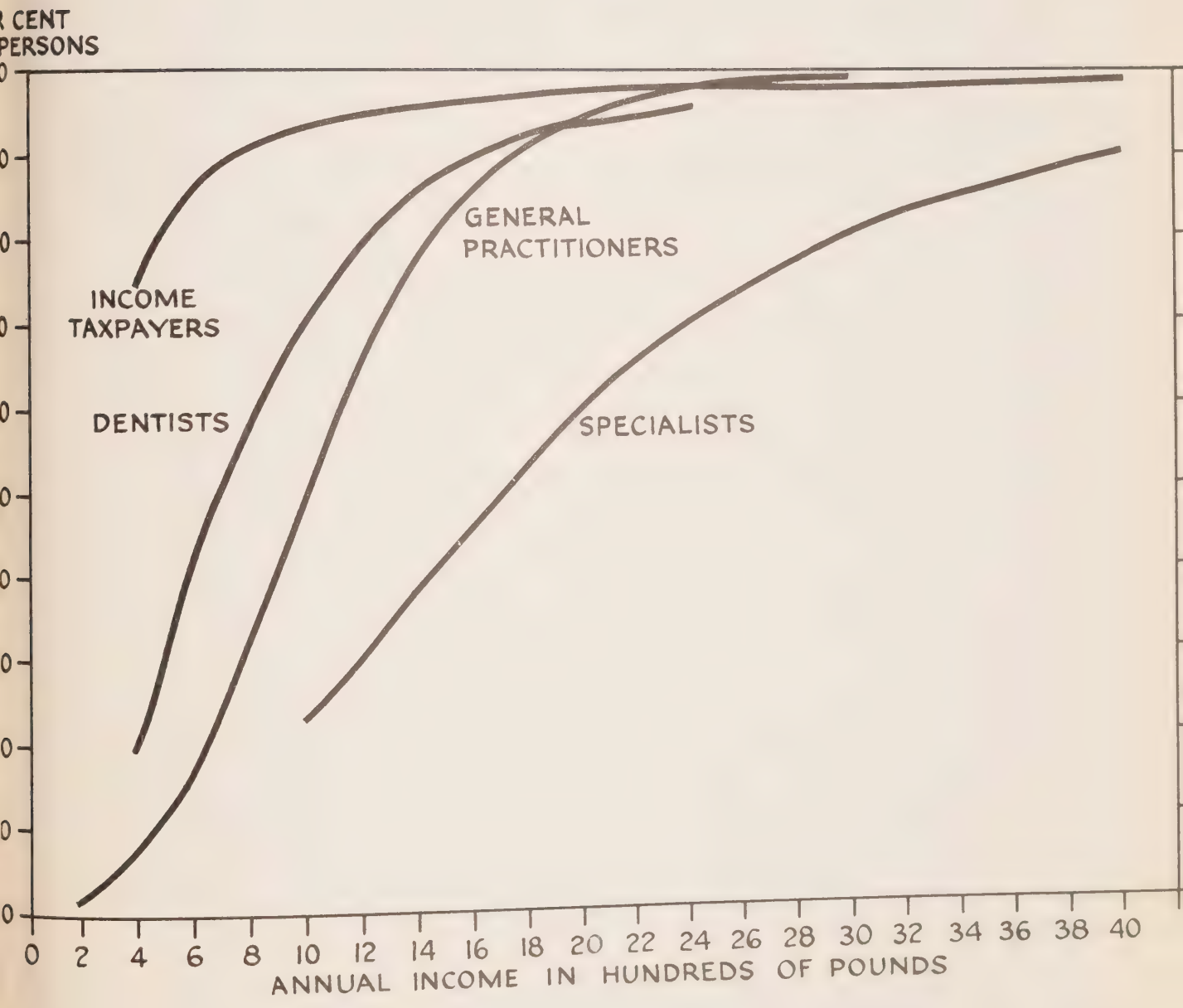
REMUNERATION OF CHEMISTS

Chemists supplying drugs and medical supplies to insured persons were remunerated on a cost-of-service basis, as set forth in a price list of drugs normally supplied, called the Drug Tariff. Capitation payments of 2s. per person entitled to obtain drugs from a chemist were paid into the Chemists' Central Fund out of the Medical Benefit Fund every year between 1912 and 1927, reduced by the portion of the "floating sixpence" described in the previous section that went to the practitioner. This payment was increased to 2s. 9 3/4d. in 1927, and 2s. 11d. in 1936. The Fund was distributed among the Insurance Committees, with the advice of the Pharmaceutical Distribution Committee, on the basis of the accounts furnished the Ministry by each Committee.

Originally the chemists submitted accounts to the Insurance Committees for the costs of drugs they had supplied. If the cost of drugs in any area exceeded 2s. per capita, the

CHART 4

CUMULATIVE PERCENTAGE DISTRIBUTION OF ANNUAL INCOMES OF INCOME TAXPAYERS, DENTISTS, GENERAL PRACTITIONERS AND SPECIALISTS, GREAT BRITAIN, 1938.



ource : Appendix X

accounts of all chemists in the region were discounted accordingly; however, special Treasury grants were made if the discount reached 15 per cent. In 1916, with the adoption of a new drug tariff designed to meet ingredient and overhead costs plus dispensing fees, the Treasury assumed the risk of meeting the full cost of chemists' accounts as priced by the new Pricing Bureaux of the Insurance Committees, wherever the Chemists' Fund of an Insurance Committee was insufficient to meet these total costs.

In 1927 a new agreement was reached with the National Pharmaceutical Union whereby the costs of drugs supplied insured persons would constitute a first charge on the Chemists' Fund, and dispensing fees would be discounted if necessary.(1) Despite attempts in 1933 and 1936 to make the payments to chemists conform to the actual costs of the services they provided, by increasing the capitation payment and arranging for supplementary payments out of balance in the Medical Benefit Fund when necessary, the costs continued to exceed the sums available.(2) So a new five-year agreement, effective in

---

(1) Discounts of 12 per cent were necessary in 1927 and 1933, of 5 per cent in 1935 and 1936, and of 7 per cent in 1937; premiums of 4 per cent, 20 per cent, 18 per cent and 4 per cent were paid in 1928, 1930, 1931 and 1932 respectively. Emergency reductions of 10 per cent and 6.3 per cent were imposed during the depression years 1932 to 1935. There was never any need to discount the accounts of Scottish chemists, who received the current wholesale prices of the ingredients used, plus a percentage of profit and a dispensing fee for medicaments.

(2) Per capita costs of drugs were as follows: 1934 2s. 11d., 1935 3s., 1936 3s.1½d., 1937 3s. 2d., and 1938 3s. 1d.

January 1938, whereby the chemists would receive payment in full for all medicines and supplies provided by them, revived the pre-1927 system of remuneration. The Minister determined the amount to be appropriated each year for this purpose out of the Medical Benefit Fund.

IX ADMINISTRATION

ADMINISTRATIVE FRAMEWORK

(1) Central Authorities

The health insurance provisions of the National Insurance Act were originally administered by a group of Insurance Commissioners in each national area. Eight Commissioners in England, and five each in Scotland, Wales, and Ireland were appointed by the Treasury, with each group including at least one general practitioner. To assist it in administering the Act, each of these groups in turn appointed an Advisory Committee consisting of representatives of employers' associations, womens' organizations, Approved Societies, and the British Medical Association. A National Health Insurance Joint Committee representing the Commissioners in each area, together with a Treasury-appointed Chairman, was responsible for coordinating the finances of the Funds in each country.

None of the Commissioners had any special experience in public health administration, and so concentrated their attention on the financial, actuarial, and legal aspects of the program. But in 1919, with the creation of a new Ministry of Health for England and Wales, and a Scottish Board of Health, the Insurance Commissions were replaced by these "Central Departments". The National Health Insurance Joint Committee was composed much as before, with representatives from each national area having the same responsibilities, but it was no longer subordinate to the Treasury. The Advisory Committees

were succeeded by Consultative Councils, appointed by the Minister of Health,(1) to be consulted concerning proposals for amending legislation, or matters affecting the Approved Societies.

The Minister had fairly wide discretionary powers under the Act, including the right to alter the rules of Approved Societies, and to approve any additional benefit schemes proposed by Societies or any practitioner-remuneration systems favoured by Insurance Committees that conformed to the requirements of the Act. One of his most important functions was to determine the methods and rates of payment to insurance doctors and pharmacists, through negotiations with their national representatives.(2) The agreements reached provided the basis for the contracts drawn up between the local Insurance Committees and the individual suppliers of services. Further, he also was responsible for distributing among the Insurance Committees the contents of the Central Practitioners' Fund, the Central Mileage Fund, and the Chemists' Central Fund, on the advice of his Medical Distribution and Pharmaceutical Distribution Committees, whose members he appointed.(3)

---

(1) In Scotland, by the Secretary of State, in Northern Ireland, by the Minister of Labour. Northern Ireland has been excluded from this bulletin since its Health Insurance Act gave only cash benefits.

(2) The Insurance Acts Committee appointed by the B.M.A., and members of the National Pharmaceutical Union.

(3) These Committees of necessity included insurance practitioners and registered pharmacists respectively.

After 1920 the Minister was assisted by a staff of Regional Medical Officers(1) who advised in cases of doubt as to the insured person's incapacity, investigated complaints of excessive prescribing, and inspected the insurance records which insurance practitioners were required to keep for statistical purposes. These officers were available for consultation in cases where insurance doctors wished the support of a second medical opinion. Similarly, the staff of Regional Dental Officers might be called upon to examine insured persons in cases where the Approved Society extending dental benefit disputed the need for the treatment proposed by a dentist, or where the dentist wanted the advice of a consultant.

The creation of the Ministry of Health in England in 1919 was accompanied by the establishment of a Central Clearing Office, administered by the Central Index Committee (a joint creation of all the local Insurance Committees), to keep a record of the members of Approved Societies entitled to medical benefits and a note of their movements between Insurance Committee areas.

(2) Approved Societies

Prior to 1911, sickness benefits had been administered by Friendly Societies or trade unions, as well as by the commercial insurance companies, whose support was considered essential to the success of the Government's original bill. Two

---

(1) The Regional Medical Staff consisted of 5 Divisional Medical Officers, 33 Regional Medical Officers, and 21 Deputy Regional Medical Officers in England and Wales.

outstanding concessions were made to bring the Friendly Societies and the industrial insurance companies into the scheme to secure their support for the whole measure: in place of a program operated solely by the State, a scheme administered by Approved Societies under general state supervision was established; and burial benefits were excluded from the cash benefits extended by the Act.

The existing voluntary agencies and insurance companies were entitled to become Approved Societies if they were operated under the democratic control of their members as "non-profit" organizations. By incorporating their health insurance departments as autonomous Approved Societies, the industrial insurance companies, as well as the trade unions and collecting societies, could qualify as administrative agencies for the National Health Insurance scheme. It was customary for the Society to pay a lump-sum to the parent body in return for the use of the administrative services of the latter. Approximately 40 per cent of the insured population were enrolled in six such Societies, in three of which there were roughly two million members each. At the end of 1939, according to the Fifth Valuation of the Assets and Liabilities of Approved Societies, there were 6,600 Approved Societies and Branches throughout the United Kingdom.

The main functions of the Approved Societies were to enroll the insured population into administrative groups, and to administer the statutory cash benefits and the additional

benefits extended by the Act.(1) The Approved Societies were responsible for keeping a record of their members' contributions and informing the Insurance Committees when members ceased to be eligible for medical benefits, for investigating and administering claims for cash benefits, and for administering schemes of additional benefits.

The Societies had no direct relationship with insurance doctors or pharmacists, but were managed (in theory) by the insured persons themselves. In practice, the Minority Report of the Royal Commission of 1926 found that probably two-thirds of the insured population could not exercise any real control in their Societies.(2) In the three largest Societies described above, the required quorum was 50 members, including any officers and members of the Society present. The Approved Societies were not organized on a territorial basis, but had their members scattered throughout the United Kingdom. As a result, workers in the same factory or in the same district might belong to several different Societies, with different schemes for additional benefits, and head offices in different cities throughout the British Isles.

Since an insured person was free to choose the Society he wanted to join, provision had to be made for persons who chose to belong to no Society. Anyone who had not joined an Approved Society within the prescribed period after becoming

---

(1) For administrative costs see p. 75.
(2) Cf. Royal Commission, Report, p. 306.

an insured person was automatically classed as a Deposit Contributor, and his benefits were administered by the Insurance Committees.

(3) Insurance Committees

Originally it was intended that the Approved Societies should administer the medical benefits extended by the Act, but the medical profession were unwilling to participate in such a scheme because of their past experience with the Friendly Societies under contract medical practice. They advocated specially-constituted Local Health Committees composed largely of medical practitioners. As a compromise, 199 regional Insurance Committees were established throughout Great Britain to administer the medical benefits of the Act. Their duties included publishing lists of insurance doctors and chemists who had agreed to supply drugs to insured persons, arranging contracts with these individuals, drawing up a scheme for remunerating practitioners, keeping the Registers of insured persons in each area up to date, administering the cash benefits of deposit contributors in the area, recommending penalties for any defaulting practitioner, and controlling the Funds through which medical benefits were financed in each area.

These Committees consisted of from 20 to 40 members,(1) of whom three-fifths were appointed or elected by the Approved Societies(2) having members in the area, one-fifth were appointed

(1) Forty to eighty until 1921.
(2) With the exception of at least one representative of the Deposit Contributors, to be appointed by the remaining 2/5 of the Committee.

by the Local Authority, two members were appointed by the Local Medical Committee, one member was a medical practitioner appointed by the Local Authorities, and the remaining member (or members) was appointed by the Minister. Thus the medical profession had a minimum of three, or possibly four, representatives on each Insurance Committee. Although this was smaller representation than the doctors had expected, provision was made for them to be consulted on medical questions through the appointment of the following special professional committees to assist the Insurance Committees in their duties:

(i) Local Medical Committees representing all the medical practitioners in each area were recognized by the Minister and consulted by the Insurance Committees on all general questions concerning the administration of medical benefits, including arrangements with general practitioners for giving treatment to insured persons, within the terms of service agreed upon by their national representatives and the Minister.

(ii) Panel Committees representing the insurance practitioners in each area were appointed by the insurance doctors to express their wishes and opinions in matters concerning medical benefit administration. In many areas the Panel Committee was also recognized as the Local Medical Committee.

(iii) Medical Service Sub-Committees were appointed by the Insurance Committees to investigate any complaints against insurance practitioners. These committees usually had six members, of whom three were appointed by the Local Medical and Panel Committees, and three by and from those members of the Insurance Committee who theoretically represented insured persons.

(iv) Pharmaceutical Committees elected by the insurance chemists in each area were consulted by the Insurance Committees on all general questions affecting the supply of medicine and appliances to insured persons.

(v) Pharmaceutical Service Sub-Committees were appointed by the Insurance Committees to investigate any complaints against insurance pharmacists; each of these committees consisted of three pharmacists appointed by the Pharmaceutical Committee, and three members appointed by and from the members of the Insurance Committee who represented insured persons.

(vi) Pricing Bureaux were set up by the Insurance Committees jointly in 1916 to price the prescriptions issued by insurance doctors and dispensed by chemists. The actual prescriptions were sent by the chemists to these bureaux, where the cost

of ingredients and appropriate dispensing fees were ascertained from the drug tariff. The bureaux kept records of each practitioner's prescriptions, and supplied the Panel Committees with information concerning instances of excessive prescribing.

The position of these local committees within the administrative framework of the National Health Insurance program is depicted in Chart 5.

COLLECTION MACHINERY

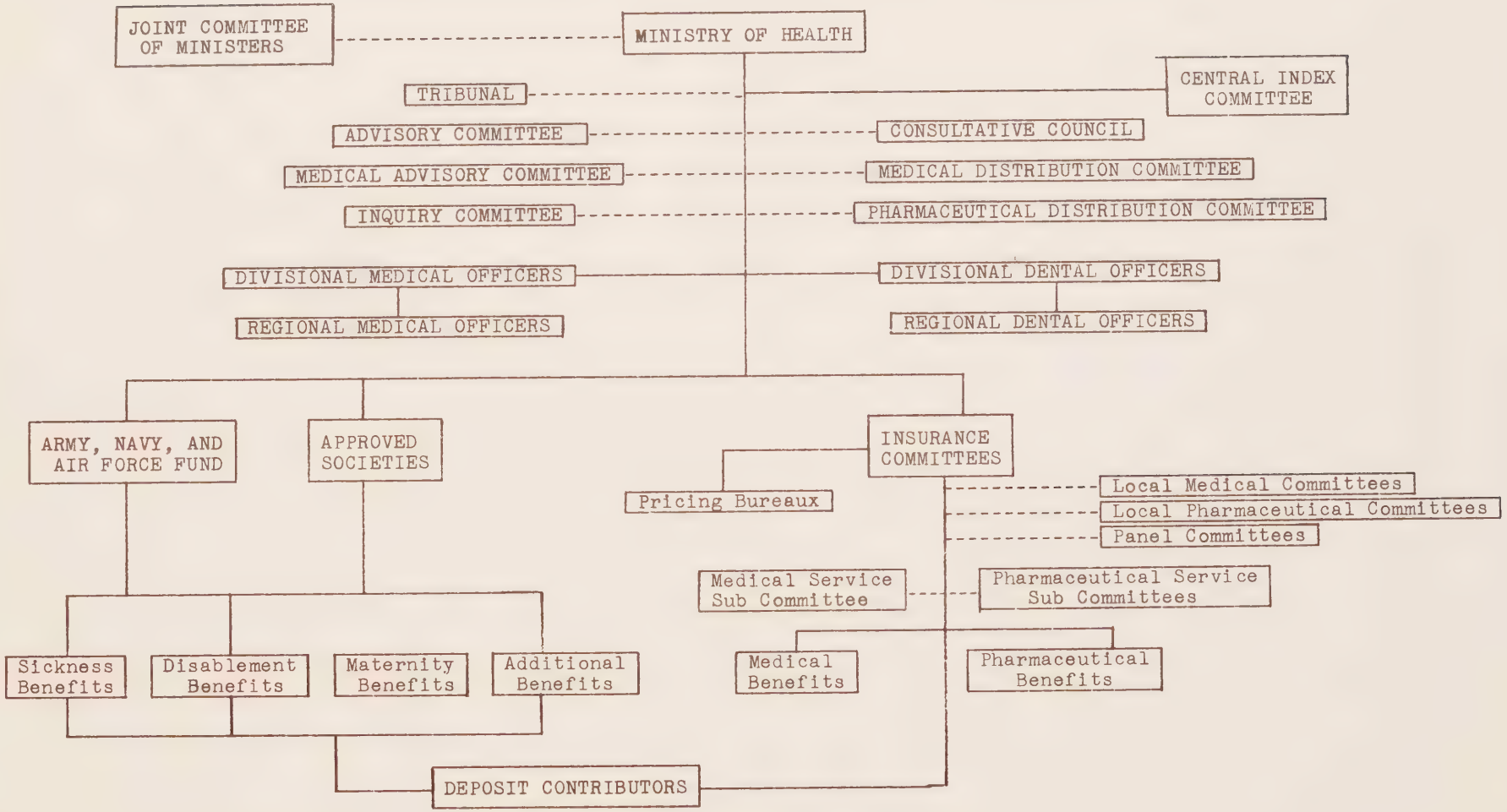
Contributions were collected by means of pay-roll deductions combined with a stamp plan for recording contributions. The employers were held responsible for the payment of each weekly contribution. Individual records of contributions were maintained by the Approved Societies.

Upon entering insured employment, an individual was expected to join an Approved Society, at which time he was issued with a six-month Contribution Card. An employed contributor who did not join an Approved Society within the prescribed time was deemed to be a Deposit Contributor, and a contribution card was sent to him by the Ministry.

The employer was legally liable for paying the full weekly contribution and stamping the card in the appropriate space; he could then withhold the employee's share from his wages. Ordinarily the stamps were purchased through the Post Office, and the receipts from the sale of stamps were credited

CHART 5

ADMINISTRATIVE STRUCTURE OF NATIONAL HEALTH INSURANCE, GREAT BRITAIN, 1947



Source: National Health Insurance Act, 1936, and related Statutory Rules and Orders.

to the National Health Insurance Fund. When a non-manual labourer was employed by the same employer throughout the year, and had no additional sources of income, it was relatively simple for the employer to enforce the income limit of £420. However, Ministerial decision was undoubtedly required in cases involving part-time employment or varying remuneration when the annual income could not immediately be determined.

The contribution card was returned to the employee on request, on expiry, or on leaving employment. The employee was expected to surrender his card to his Society (or to the Ministry if he was a Deposit Contributor) on transfer to another Society, on becoming a voluntary contributor or ceasing membership altogether, or within 14 days after the card expired. The Approved Society kept an individual record of each member's contributions; the contribution cards, collected semi-annually from the members, were surrendered to the Ministry where the stamps were counted and their value credited, after deductions, to the account of the Society. Each member kept a record of his contributions and arrears by means of a Record Card, issued to him at the same time as his first contribution card, and kept up to date for him by his Society (or the Ministry).

If an insured person wanted to pay arrears, he applied to his Society or the Ministry for an Arrears Card which he returned after attaching the appropriate number of stamps.

Special contribution cards were issued to voluntary contributors by the Approved Society or the Ministry; unlike the ordinary Contribution Cards, these could not be supplied by postmasters. The voluntary contributor stamped his own card, and surrendered it to his Society or the Minister on expiry, on transfer, or (if a female) on marriage.

Each Society kept a Register of its members, and issued a card, or "index slip", for each of its members showing the name, address, and membership number. These slips were sent to the Central Clearing Office where the Central Register of insured persons was kept. The Clearing Office was notified of any change in a member's status or eligibility for benefits, and in turn referred the information to the Insurance Committees. Each Insurance Committee kept two Index Registers - card indexes of the insured persons eligible for medical benefit in its area - one arranged according to the Society chosen, the other according to the doctor chosen. Thus there were four Registers of the insured population. In Scotland no Central Register was kept; instead the Approved Societies notified the Insurance Committees directly when a member ceased to be eligible for medical benefit.

ADMINISTRATION OF BENEFITS

(1) Medical

Each Insurance Committee prepared a "Medical List" or "panel" of doctors in the area who undertook to give medical treatment under the conditions of the scheme. Any doctor was

free to have his name put on the list by notifying the Committee of his wish, and a patient was free to choose any doctor on the list. Similarly, any registered pharmacist could have his name included on the list of persons eligible to supply drugs, medicines, and appliances to insured persons.

Upon receipt from an Approved Society, via the Central Clearing Office, of an index slip indicating that a newly-insured person resided in its area, an Insurance Committee sent him a Medical Card telling him what he must do to get medical benefit. The insured person chose an insurance doctor from a list displayed in the Post Office, and asked him to sign the card and return it to the Insurance Committee in the area. The latter added this person's name to the doctor's "panel" of patients, returned the card to the insured person to be produced as identification when seeking treatment, and sent a medical record to the doctor for his card index. This record served as a case-paper for all the illnesses of that patient, to be forwarded to any subsequent doctor he might choose in the future.

The insured person could present his medical card to an insurance practitioner in any area where he was temporarily residing, or in an emergency, and obtain treatment. If the doctor doubted the patient's eligibility for medical benefit, he could charge a refundable deposit. To change his doctor, the patient requested the new doctor to sign Part B of the Card and send it to his Insurance Committee; the latter issued a new card

with the new doctor's name in Part A, returned it to the patient, and transferred the patient's name to the new doctor's panel. Such tranfers could be made at any time if the old doctor consented, or at the end of each quarter on notifying the Committee a month in advance. If the insured person moved to a new area, the new Insurance Committee made application via the Central Clearing office, (on the form contained in the medical card), for the index slip held by the old Insurance Committee. On receipt of this request, the latter removed the insured person's name from the old doctor's panel. Similarly, when notice was received that an insured person would no longer be entitled to medical benefit, his name was removed from the panel and the practitioner was notified to that effect.

One of the consequences of extending an extra period of free insurance(1) to insured members of a Society who ceased to pay contributions, was to permit the Approved Society to issue a special notice to the Central Clearing office cancelling the insured person's index slip when he failed to submit a stamped contribution card in respect of any half-year. The Central Office in turn notified the Insurance Committee concerned, which was thus enabled to inform the person's doctor that, as of a particular date in the future, this patient would no longer be entitled to medical benefits.

(2) Pharmaceutical

An insured person was free to have his prescription filled by any insurance pharmacist, who in turn submitted it to

(1) See p. 59.

the Insurance Committee as his voucher for payment. As indicated above, the Pricing Bureaux kept a record of the cost of prescriptions issued by each practitioner as a check on excessive prescribing. This cost was compared with the average cost of all the practitioners in the area; the Regional Medical Officer visited any doctor whose prescribing appeared overly expensive to discuss how greater economy might be achieved. If the practitioner's prescription expenses remained consistently above the average, the local Panel Committee was asked to make an estimate of the resulting excess cost. If he appealed to the Minister, his case was heard by an independent tribunal of three medical Referees appointed by the Minister. On the basis of their report, or of that of the Panel Committee if there was no appeal, the Insurance Committee might recommend to the Minister that he withhold such sum as he might see fit from the doctor's remuneration. In this way a practitioner was subject to the discipline of other members of his profession - of the Regional Medical Officers, of his local Panel Committee, and of an independent medical tribunal - when his professional discretion was called into question.

(3) Certification for Cash Benefits

If in his doctor's opinion an insured person was incapable of working, he could request the doctor to provide him with an initial medical certificate of incapacity, free of charge. An intermediate certificate was required for every week of continued incapacity, and a final certificate when the doctor

believed the patient capable of resuming work.(1) On each certificate there was a space the insured person could use to make a claim for sickness or disablement benefit. These claims were either given to the local representative of his Society or mailed to the Society's head office. A deposit contributor sent his claim to the local Insurance Committee. From its records, the Society would determine the claimant's eligibility for benefits in terms of his contributory record, his age and his previous claims during the year, and might require him to produce his contribution card as evidence that he had made the minimum number of contributions.

If, however, as a result of a visit paid by its own sickness visitor, the Society disputed the fact that the patient was incapacitated, the case was immediately referred to the Regional Medical Officer for re-examination. The Society was the final judge as to whether cash benefits would be paid. As a result, every person certified for cash benefit was supposed to be visited by a sickness visitor on the same day that the certificate was received, if possible, and in any event before the first payment of benefit was due; further visits were made at frequent intervals during the period of incapacity. The primary function of the sickness visitor was to report on the medical condition of members receiving benefit.(2) If the Society or the practitioner doubted the patient's incapacity

(1) Cf. R.W. Harris and L.S. Sack, Medical Insurance Practice, (4th Ed., B.M.A., London, 1937), c. IX.
(2) Cf. Approved Societies Handbook, (HMSO, London, 1933) p.113.

to work and desired a second medical opinion, the Regional Medical Officer was called upon to examine him, and the practitioner was invited to be present. "Consultation references" might also be made to the Regional Medical Officer if a practitioner wanted advice regarding diagnosis or treatment. On the basis of the Regional Medical Officer's findings, the Society decided whether or not to pay (or to continue paying) sickness or disablement benefits.

COMPLAINTS AND APPEALS

Although the Minister had the final authority to settle any complaints against practitioners that arose, he was assisted in reaching his decision by an Advisory Committee in cases of improper certification of illness, a Medical Advisory Committee in cases of negligence in treatment, and an ad hoc Inquiry Committee in cases where the proposed penalty involved removal from the panel, as well as by the independent tribunal of medical Referees to which all appeals were referred.

Complaints against insurance practitioners made either by insured persons or Approved Societies were investigated in the following manner. The Medical Service Sub-Committee heard the complaint in the first place, and made its report on the facts and its recommendations to the Insurance Committee. After the latter had reached its decision on the complaint, either party might appeal the decision to the Minister. Where the complaint involved negligence in the treatment of a patient, the Minister, who had the power to make the final decision,

consulted the Medical Advisory Committee of three departmental medical officers and three practitioners, selected by the Minister from a slate nominated by the Insurance Acts Committee of the British Medical Association. If the complaint was upheld, the practitioner's remuneration might be reduced, or his name might be removed from the panel if a specially-constituted Inquiry Committee so decided. In 1938 remuneration was withheld in 84 cases in England, of which only 11 involved negligence, and no practitioners were removed from panels.

If the Ministry's records revealed that an unusually high proportion of the patients of a given practitioner had ceased to draw cash benefits after reference to the Regional Medical Officer, and if there was evidence that he had issued certificates indiscriminately, he was visited by the Regional Medical Officer and invited to give an explanation. If the careless certification continued, the Panel Committee was requested to recommend any necessary action. Before withholding any of the practitioner's remuneration, the Minister had to consult a 13-man Advisory Committee of representatives of insurance doctors, Insurance Committees, and Approved Societies. Because disputed questions were thus referred to impartial committees on which the doctors were represented, there was comparatively little friction between the insurance practitioners and the medical officers.

However, in view of the complex procedure involved, it is manifest that only in very serious cases would patients contemplate registering complaints. Most cases of

dissatisfaction would not come to the attention of the authorities because the patients would not consider them serious enough. Dr. Comber of the National Medical Union declared before the Royal Commission, "I think all those of us who are attending the panel patients of other men are very well aware of the fact that there are a large number of cases which would legitimately be a cause of complaint, only no complaint has been made."(1) And Mr. Henry Lesser, Vice-Chairman of the Insurance Committee for the County of London, said "the number of people who make complaints to the Insurance Committee are an infinitesimal fraction of the number of people who complain without bringing their cases before the Insurance Committee."(2) Thus it cannot be concluded that the complaints machinery was entirely satisfactory.

---

(1) Royal Commission on National Health Insurance, Minutes of Evidence, (HMSO, London 1925), Vol.III, Q.15, 796.
(2) Ibid - Vol. IV, Q. 22, 900.

X ASSESSMENT OF THE SCHEME

The observations contained in this chapter have for the most part been taken from authoritative British sources that reported on the operations of the scheme throughout its lifetime, particularly the Report of the Royal Commission on National Health Insurance of 1926. Wherever possible direct quotations from these sources have been included.

Critics of the British insurance program suggest that its chief limitations were the restriction of coverage to wage-earners only, the failure to provide medical care beyond ordinary general practitioner treatment or hospital care, the inadequacy of the cash benefit provisions, and the inability of the administrative authorities to coordinate the insurance medical benefits with any of the public health services provided by the Local Authorities. Most writers believed that the multiplicity of Approved Societies administering the scheme led to a great deal of waste and duplication of effort. Objection was also raised to the actuarial principles on which the scheme was financed with its emphasis on flat-rate contributions and reserves and its disregard for the part that government grants might be expected to play in a state program.

It was recognized at an early date that the National Health Insurance program was not meeting all the objectives which had originally been set, particularly that of providing for "the prevention and cure of sickness". The medical profession in particular was dissatisfied with a scheme which fell

far short of providing for the nation the uniform medical service that was its expressed aim.(1) It was its recognition of the need for coordinating the preventive measures of the public health services with the curative aspects of the insurance medical service that led the Royal Commission to recommend that ultimately the general practitioner service should be divorced from the insurance system and, in close co-operation with the public health services, should be financed out of general public revenues.

COVERAGE

This belief that eventually the scheme must be brought into the public health services caused the Royal Commission to omit from their recommendations the provision of medical benefit to dependents, because "one effect of including the dependents in the medical service of the present Insurance Scheme might be to impede or postpone any ultimate unification of health services".(2) Mr. Brock of the Ministry of Health stated in evidence that, "If it was proposed to provide either a general practitioner service or a complete medical service, for the whole industrial population, there are strong arguments in favour of providing this service out of local funds and making it available to all sections of the population."(3) Mr. Alban Gordon, a member of the London Insurance Committee, believed

(1) Cf. Hermann Levy, National Health Insurance: A Critical Study, (Cambridge University Press, 1944), p. 21.
(2) Royal Commission, Report, p. 163.
(3) Minutes of Evidence, Vol. IV, Q. 23,847.

that extension of medical benefit to dependents "would stereotype the present system so deeply as to render it far more difficult to bring into existence at any future date the co-ordinated medical service which the health of the country so urgently needs".(1)

Whatever the reasons, one of the chief deficiencies of the British scheme was its failure to extend medical benefits to the children(2) or other dependents of insured persons. In consequence, only about 50 per cent of the entire population was covered by the scheme even during its peak period. Voluntary insurance was found to be unpopular with the self-employed group, and so was not extended to them after 1918; by the exclusion of these people from the system, the opportunity of spreading the risk over a large segment of middle-income persons was lost. Furthermore, evidence was submitted at the time of the Royal Commission, and subsequently by other writers, that the exclusion of the upper income groups and non-manual labourers earning over £420 led to the development of two standards of medical service - that given the private patient and that given the panel patient. For example, Mr. Saunders, Vice-President of the National Conference of Friendly Societies, stated before the Royal Commission: "In my opinion the service leaves much to be desired, and there cannot be any question in my mind but that there is still today a distinction made

---

(1) Royal Commission, Report, p. 164
(2) It should be pointed out however, that the Maternal and Infant Welfare, and the School Health services were available to these dependents.

between the panel patient and the private patient and the respect shown by the medical man to the respective classes of patients."(1) Dr. Comber of the National Medical Union gave some very striking examples of negligent and inadequate treatment by panel doctors.(2)

In a scheme where only a limited proportion of the population is covered for health insurance benefits, there arises the problem of distinguishing between those persons who are entitled to benefits, and those who are not. In Britain an elaborate card system was developed to meet the problem, together with a complicated system of registration and collection of contributions. "It is clear that a considerable portion of the difficulties arise from the fact that medical benefit is administered by bodies organized on a geographical basis, that insured persons move frequently from place to place, and that information as to the insured person's title to benefit can be obtained solely from his Approved Society which has itself no adequate means of tracing its members' movements."(3)

BENEFITS

It was indicated above that the standard of medical care under insurance practitioners left something to be desired. There was considerable evidence before the Royal Commission that the opinion was widespread among the beneficiaries of the scheme that insured patients received a lower standard of care than

---

(1) Minutes of Evidence, Vol. II, Q. 11,005.
(2) Ibid, Vol. III, Q. 15, 796.
(3) Ibid, Appendix, Part I, P. 96.

other fee-paying patients. As Levy(1) has pointed out, it seems erroneous to regard the limited number of cases of official complaints as evidence of the efficiency of the panel doctor system, since only the most serious complaints were registered through the official machinery. An additional criticism of the insurance practitioners was that they passed on to the hospitals as much of their work as they possibly could. "The panel doctor is in many cases only too willing to shift the patient to hospital and so get rid of the case altogether."(2) The Political and Economic Planning Report in 1937, in asserting that the general practitioner has to perform the key function in any coordination of the health services, indicated at the same time the need for limiting the size of a practitioner's panel and the amount of certification that might be required of him. "Excessive numbers of panel patients and excessive demands for certificates and returns of all kinds quickly reduce the general practitioner to an agent for making out prescriptions, and for operating something more like a sickness licensing and registration system than a health service."(3)

However, a more serious criticism of the British scheme, and one that was made by almost every independent writer on the subject, is that the statutory medical benefits extended to insured persons were limited to ordinary general practitioner treatment, including only minor surgery - treatment

---

(1) Levy, Op. cit, p. 115.
(2) Ibid, pp. 161, 113.
(3) PEP, Op. cit, p. 397.

that was "within the competence of any general practitioner". It was deemed inequitable to require a doctor with extra skill to render a wider service than other doctors on the panel gave in return for the same capitation payment. Ophthalmic and dental treatment, physiotherapy and psychotherapy were offered only by certain Societies as additional benefits; hospital treatment was outside the administration of the health insurance system - when offered as an additional benefit it amounted only to cash indemnification of the insured member for a part of the cost of approved treatment; and maternity and specialist treatment were not offered even as additional benefits. Instead, hospital, maternity and specialist services were supplied by the municipal authorities, semi-charitable institutions, or other private agencies, with no attempt to coordinate such services with those of the insurance practitioner.

The Royal Commission had suggested that a specialist service should be added to the medical benefits of the scheme, and that the closest cooperation between the general practitioners and the specialists should be secured in order to improve the standard of medical service. "One of the weaknesses of the present system (is) that you cannot secure that kind of close cooperation (between practitioner and consultant), and it is doubtful whether you could ever get the co-operation carried out satisfactorily unless the consultant and the practitioner were responsible directly to the same body."(1) Since

(1) Minutes of Evidence, Vol. IV, Q. 23,835.

specialist services were not included in the medical benefits extended by the Act, the Insurance Committees could scarcely be expected to foster cooperation between consultants and general practitioners. The Government White Paper on the National Health Service indicated two major reasons why the panel system under health insurance could not be expanded to cover the whole population and to provide specialist services in the hope of solving the need for increased medical care. In the first place, there existed, under the panel system, no efficient means of securing the necessary distribution of doctors for a universal general practitioner service. And in the second place, the organization necessary to encourage and experiment with changes in the technique of medical practice was not available. With developments in the practice of modern medicine, it was generally agreed by the end of the National Health Insurance program that a doctor must have at his disposal the basic facilities for diagnosis and treatment, and access to consultant and specialist opinion, in order to function efficiently.(1)

The British system of health insurance did recognize the need to maintain a worker's income while he was ill or disabled. Cash sickness benefits were an integral part of the scheme. But many writers have protested that they were quite inadequate to support a worker and his family while he was unable to work. Some Societies did pay additional cash benefits,

(1) Ministry of Health, A National Health Service, (London: HMSO, 1944), pp. 27-8.

but the statutory benefit rate was somewhat below the rate for unemployment insurance benefit, which supposedly had been set at "the subsistence level". No attempt was made to graduate the cash benefits according to the previous income of the insured person; everyone received the same statutory rate of payment. And, although a cash payment was made in lieu of treatment for confinement cases, the actual amount paid was totally inadequate to cover the cost of the confinement, quite apart from the loss of earnings during that period. Even the municipal Maternal and Infant Welfare programs could not make up this deficiency.

The combination of cash benefits and medical benefits supported out of the same Fund meant that any extension of medical benefits was dependent upon a decrease in the incidence of illness among the members of a Society. Within the administrative framework of the British program, it was clearly impossible for Societies with members scattered throughout the Kingdom to implement measures which would reduce the number of weeks of sickness per member per year. The National Insurance Act and the National Health Services Act of 1946 gave recognition to these difficulties by completely separating the administration and finance of medical and sickness benefits, the former receiving financial support out of general revenues and the latter out of contributions to the central social insurance Fund.

With the sickness experience of individual Societies varying considerably, depending upon the occupational groups

and localities involved and so on, the additional benefits that these Societies were able to offer their members were extremely diversified. Insured persons paying uniform weekly contributions were thus entitled to very unequal benefits under the Act, depending on the Approved Societies to which they happened to belong. By making the additional benefits available to the members of a given Society conditional upon the incidence of illness among these members only, the fundamental principle underlying a national insurance scheme - the spreading of the risk of illness over the whole or a large part of the population - was ignored. The great disparity in the additional benefits offered by different Societies could have been avoided had the funds available for treatment benefits in each Society not been dependent on the surplus remaining after the claims of the members of that Society for cash sickness benefits had been met. "Under the Approved Society System it is impossible to use the whole resources of National Health Insurance to the greatest advantage of the insured population as a whole."(1) Insured persons who were considered to be bad health risks were usually debarred from membership in Approved Societies, and so became deposit contributors with no title to additional benefits. Thus the least healthy persons got the least benefits under the British system of administration.

It must not be inferred that the medical benefits under the Act, as far as they went, were not superior to the

(1) Royal Commission, Report, p. 303.

services that had previously been available to a large part of the population. In addition to the services of a general practitioner, an insured person was entitled to whatever drugs and medical supplies his condition warranted. Almost two years of free insurance were extended to persons leaving the scheme; as a result, practitioners could be notified well in advance when benefits were to cease. The need for medical benefits during long periods of unemployment was given recognition by means of a period of extended insurance. Despite the complications involved in the transfer of patients between doctors, the important principle was maintained that patients must be free to choose their own doctors, and doctors must be free to refuse patients. The doctors were not employees of the State, but were free to use their own professional discretion on every occasion, subject only to review of questionable practices by independent bodies composed of other doctors.

FINANCE

The limitations on benefits and coverage indicated above were occasioned partly by the administrative framework within which the program operated and partly by the financial structure of the scheme. From the beginning it was intended that the insurance Fund should be as nearly self-supporting as possible. To this end, the contribution rate was fixed so as to provide an amount which would be the actuarial equivalent of the benefits a contributor was expected to receive during his lifetime if he had entered insurance at 16 years. These

calculations were based on the assumed average of one week of sickness per member per year.(1) The government contribution was designed to meet the reserve values (equivalent to contributions plus interest retroactively to age 16 years) established on behalf of persons entering insurance at ages above 16 years. Thus the benefits of the scheme were strictly limited by the flat-rate contributions adopted, the accuracy of the illness rate assumed, the minor role assigned to Exchequer grants, and the size of the reserves it was deemed necessary to maintain.

Because the Approved Societies were competing with one another for members from all occupational groups and all localities on an individual basis, the varying risk-proneness of such a heterogeneous membership could not be estimated. Therefore the cash benefits of the scheme, and consequently the contribution rates, could be actuarially planned on a flat-rate basis only.

Although the British program was one of compulsory insurance, one of the principles of finance more appropriate to a voluntary program was followed. "While full and ample reserves are necessary for a system of insurance based upon voluntary contracts, a compulsory system may consciously adopt an assessment system, under which the amount of funds to be raised annually by contribution is largely determined by the amounts of money to be paid out and expended annually."(2)

(1) I.M. Rubinow, Standards of Health Insurance, (Henry Holt and Co., New York, 1916), p. 219.
(2) Rubinow, Op. cit., p. 221.

Instead, the British authorities made provision for the accumulation and investment of large reserves, the interest on which, together with the fixed annual contributions, determined the amount of money available for benefits. It is interesting to note that both Rubinow and Levy agree that, if the insured population had been organized into one fund with an integrated risk-expectation, it would not have been necessary for a portion of the insurance premiums to be plowed back into reserves each year; contribution receipts could have been equated with benefit expenditures, and any deficit met out of general revenue. By adopting a fixed uniform rate of contribution, the British authorities committed themselves to a regressive head-tax system of finance in place of one based on the insured persons' ability-to-pay. However, the government's annual contribution from general tax revenues of an average of 17 per cent of the receipts of the National Health Insurance Fund, primarily intended to offset the deficit due to the entry-age problem referred to in Chapter VII, in effect recognized the principle of ability-to-pay to a limited extent.

The fragmentation of administrative responsibilities under the scheme among thousands of Approved Societies led not only to high per unit overhead costs in administering the scheme,(1) but also to the serious disparities in additional benefits mentioned in the previous section. Societies with a high proportion of miners, cotton-workers, or chronic

(1) See p. 76.

sufferers in their membership were less likely to have surpluses after meeting all the claims for cash sickness benefits than were Societies composed largely of agricultural workers. Levy(1) suggested that contributions based on earnings, up to statutory maxima, might vary from one area to the next in order that sufficient flexibility might be given to the scheme to enable it to be adapted to the particular requirements of a given area. With the decentralized financial structure of the British scheme, periods of heavy unemployment such as that which prevailed in 1930-35 severely crippled the ability of individual Societies to meet the needs of their members without substantial State support. Very often Societies with a large proportion of bad-risk members were forced to be very stringent in determining their members' title to benefits, thus defeating the efforts of the scheme to provide curative and preventive treatment for those people who needed it most. "It is suspected that the incentive to good management, which is so much stressed by defenders of approved societies, sometimes leads to injustices to the insured person".(2) The size of the surplus built up, rather than the ease with which disabled insured persons were able to get the benefits to which they were entitled, was usually cited as evidence of "good management". ". . . the effect of an incentive with the purpose of economising on benefits is definitely vicious. Saving the funds by curtailing the benefits

(1) Levy, op. cit., pp. 343-4.
(2) P.E.P., op. cit., p. 207.

of the sick persons and forcing them back to work . . . is not a feature that is either economical in the long run, or moral in a State scheme. . . ."(1)

The collection machinery underlying the British program was quite efficient. With payroll deduction of contributions, the use of the employer-liability principle, and the sale of stamps through post-offices, the collection of premiums was inexpensive and effective. The methods of paying practitioners for their services were also simple and effective. A capitation payment for each insured person on a doctor's panel constituted a fairly stable expenditure from year to year, and guaranteed the individual practitioners in poor districts an adequate income during prosperity or depression. Extra grants in the form of rural aid or mileage payments were made to attract practitioners to "under-doctored areas", but insurance practitioners were not permitted to charge any extra fees for treatment within the scope of the Act given to their insured patients.

ADMINISTRATION

In commenting on the administrative defects of the program in 1944, Levy wrote: "It is not the principle of covering sickness by insurance that has failed, but the British system of National Health Insurance."(2) "The British system of health insurance was not the outcome of an impartial choice from the many possible alternatives of the most appropriate

(1) Royal Commission Report, p. 308.
(2) Levy - Op. cit., p. 342

scheme. The existing institutional framework had to be taken into account whatever its merits. Vested interests were to be consulted and their support secured."(1) The inclusion of representatives of all the conflicting viewpoints in the original Advisory Committee had a very significant influence on both the objectives and the final administrative framework of the scheme. And again, "A scheme.....approaching the conception of a general service to all citizens who cannot afford complete and proper treatment.....could not be achieved in this country without fundamental changes in the administrative machinery."(2) In particular he believed that the Approved Societies should have been replaced by centrally-coordinated territorial or occupational administrative units with the authority to vary the contribution rates in accordance with the average sickness experience of the area or occupation. The Minority Report of the Royal Commission had recommended that the work of the Societies should be taken over by the Local Authorities, thus reducing the number of units from about 8,000 to 150. Without going this far, the Majority Report recognized the need for greater control over the rules, administration, and expenditure of the Approved Societies. These voluntary self-governing Societies gradually became quasi-public bodies, as the Ministry was forced to exercise closer supervision of their affairs to achieve uniformity in the

---

(1) Ibid - p. 37.
(2) Ibid - p. 49.

administration of additional benefits and to demand amendment of rules to which exception was taken.

The multiplicity of these small administrative units resulted in a great deal of overlapping and waste in administration. The Royal Commission Report, in commenting on this overlapping and duplication of effort, stated that 98 Societies at one time had each only one member in Glasgow. The Report of PEP cited the case of a company in South-west England with 337 insured employees having membership in 36 different Societies, 28 of which had 5 or fewer members among these employees. "A remarkable number of these Societies are local or regional rather than national organizations, with their interests many miles away, and the management complain that it is practically impossible for the workers to get satisfactory advice upon the choice between these Societies or to judge in what circumstances transfer is worthwhile."(1)

The Approved Societies were also criticized for their high costs in administering cash benefits as compared with the administrative costs of the Insurance Committees. "It must be fairly recognized that the Approved Societies have considerable expenditure in furnishing records to the Insurance Committees...which ought to be shown as part of the administrative expenditure on medical benefit; and admittedly the relative duties involved in administering cash benefits and medical benefits are of a different character and extent.

---

(1) PEP - Op. cit., p. 209.

But it is really difficult to suppose that if the medical benefit can be administered at a cost of 4 per cent, the 20 per cent charge for administration of the cash benefits is justified."(1)

The Majority Report of the Royal Commission found the Insurance Committees to be redundant, inasmuch as the central departments made collective bargains with the medical and pharmaceutical professions, the pricing bureaux assessed the value of chemists' accounts, and the medical service sub-committees investigated complaints against practitioners. Therefore they recommended that the duties of the Insurance Committees should be taken over by the Local Authorities, so that all the local health services might be effectively co-ordinated under one authority responsible to the electorate.

The Minority Report went even further: they suggested that the duties of the Approved Societies should also be taken over by the Local Authorities, for they considered the administration of sickness cash benefits to be a health service. The questions of disability and the issue of medical certificates were, they said, an integral part of medical service; if the Local Authorities were to take over the functions of the Insurance Committees, they should also administer this aspect of the doctor's service. The Local Authorities were in a better position to investigate claims, and to make prompt payment of benefits than were the Approved Societies with their widely-scattered membership. With

(1) Harris, Op. cit., p. 97.

regard to maternity benefits, it was felt that the Local Authorities could do much more than simply hand over a lump sum to new mothers, for they already administered the Maternal and Infant Welfare services. The Approved Societies were not qualified to assess the value of the services rendered to their members under the additional benefit programs; all they could do was to pay sums of money to certain of their members selected on a medical basis. The Minority Report considered the Local Authorities better able to assess the value of such treatment rendered to insured persons, for they were already responsible for other public health services within their areas. The transfer of the functions of the Societies to the Local Authorities would have increased the possibility of effectuating those provisions of the 1911 Act aimed at the prevention of sickness.

A further argument supporting this transfer of responsibilities was that democratic control of the administration of benefits by the insured persons, which had become a fiction under the Approved Society system, would be encouraged. It was said that all powers which could and should be locally exercised, ought to be concentrated in the hands of the Local Authorities and that an administrative system which included Societies formed by the large commercial insurance companies, and administered by their own agents who were naturally anxious to sell commercial insurance, could scarcely be called self-governing.

Because the membership of each Society was scattered throughout the whole Kingdom, the Societies were quite impotent in the struggle for solutions to the problems of sanitation, housing, and nutrition insofar as these factors affected the health of insured persons. Neither the Approved Societies nor the Insurance Committees were in a position to promote measures for the improvement of the nation's health, and there was apparently no attempt to coordinate the insurance medical service with any of the other public health services. Both the Committees and the Societies, preoccupied with administrative details, were unable, through lack of time, money, or inclination, to initiate measures for the improvement of the standards of medical practice or preventive medicine, to influence medical education or the supply of doctors, or to persuade practitioners to adopt new techniques. The Highlands and Islands scheme, the specialized grants to rural doctors, and the postgraduate courses for practitioners were all State-sponsored and financed programs. "One would expect of a body directly concerned with the administration of medical benefit that, from its experience, suggestions and experiments in organization, actual improvements in the administration of medical treatment would result. It is the complete absence of this process that constitutes the major charge against the work of insurance committees."(1)

The British Medical Association in evidence before the Royal Commission stated that: "It is essential not only

(1) Levy, Op. cit., p. 271.

that the attention of all practitioners should be directed continually to the preventive aspects of their work, but that the existing machinery and medical officers of the Public Health Service should be brought into close and organic connexion with the Insurance Scheme."; and that "It is desired to make all such benefits and services" (such as pathological facilties, tuberculosis and venereal disease treatment, treatment of school age children, maternity and infant welfare services) "an integral part of the Insurance Scheme or to bring them into proper relationship thereto".(1) The Medical Officers of Health stated that "it is true that the administrations are amalgamated in one Government Department, but such an amalgamation is of comparatively little value if the practical and detailed working of each in local areas is ill co-ordinated or impossible," and again, "The need for some genuine co-ordination of all the medical agencies in every area has long been severely felt."(2) The National Conference of Friendly Societies concluded their evidence by stating: "It is, therefore, suggested that the best way of organizing the provision of medical treatment is to merge all existing forms of public medical service (including medical benefit under the National Health Insurance Acts) into one National Medical Service, thereby creating one unified organization for the prevention and cure of disease".(3) The Royal Commission

---

(1) Royal Commission Report, p. 56.
(2) Ibid., p. 56.
(3) Ibid., p. 58.

concluded that, granting the need for effective coordination of all the health services, "The ultimate solution will be in the direction of divorcing the medical service entirely from the insurance system and recognizing it along with all the other public health activities as a service to be supported from the general public funds."(1) Cash benefits during periods of sickness would, on the other hand, be coordinated with old age pensions and unemployment insurance in a unified social insurance system financed largely through contributions.

Despite all these criticisms of the administrative framework of the British health insurance program, several commendable features have been noted by various authorities. Early attempts to supervise the scheme by groups of Insurance Commissioners were soon dropped, and the administration handed over to a new government department, the Ministry of Health, thus bringing the scheme under the control of the elected representatives of the people. At both central and local levels, the actual administration of the benefits extended by the Act was largely in the hands of joint lay and professional committees, with representation of the insured persons and municipal authorities as well as the suppliers of professional services. Professional committees acted in an advisory capacity on professional questions concerning the standard of treatment or the exercise of professional discretion, both to the Insurance Committees and to the Minister. But the final

---

(1) Ibid., pp. 65 - 66.

decision as to penalties in such cases, or matters of general administration, rested always with bodies representative of both the insured population and the general public.

CONCLUSION

This bulletin has attempted to describe 35 years of experience under British health insurance in the hope of gaining a valuable perspective on the present National Health Service program.

The founders of the new scheme have attempted to remedy the defects of the earlier program by the provision of complete medical and hospital care - including specialist, consultant, nursing, dental, and ophthalmic treatment - to all persons in the United Kingdom, without regard to an individual's social insurance status. Medical services are now entirely divorced from the insurance system, while cash sickness benefits are coordinated with unemployment insurance and the other social insurance benefits under the National Insurance Act of 1946. Undoubtedly these developments were hastened by the war-time emergency health service organization, and the need to meet the many problems in the field of health care accentuated by the country's war experience.

The capitation system of remuneration has been continued under the National Health Service Act, but the attempt to finance the scheme largely out of contributions has been abandoned. General revenues now provide all but a very small proportion of the finances of the program. To the extent that

the British tax structure is progressive, the heaviest burden of the health services falls upon those taxpayers with the greatest ability to pay for the scheme.

In addition to the extension of a comprehensive medical service to everyone in the country, financed out of general revenues rather than by contributions, the new Act transferred the administration of all health services in Great Britain to three closely-coordinated bodies - the local health authorities, the regional hospital boards, and the local executive councils - responsible respectively for public health services, hospital and specialist services, and general medical, dental, ophthalmic and pharmaceutical care.

Thus the 1926 recommendations of the Royal Commission on Health Insurance (and indeed those of the Minority Report of the Royal Commission on the Poor Laws of 1909) and of most other reports on the scheme since that time, that medical services should be coordinated with all other public health services and supported largely from public funds, have finally been implemented.

APPENDICES

APPENDIX I

HOSPITAL ACCOMMODATION IN GREAT BRITAIN
BY TYPE OF HOSPITAL AND NUMBER OF BEDS, 1939

Type of Hospital	Total No. Beds	No. of Hospitals		
		Public	Voluntary	Total
England and Wales				
Specialized Voluntary	75,140	-	230	230
General Voluntary[a]		-	700	700
" Public	62,642	185	-	185
" Poor-law	52,465	415	-	415
Infectious Disease[b]	39,000	810	-	810
Tuberculosis[c]	28,800	258	101	359
Mental	135,000	101	62[d]	163
Maternity[e]	12,555	440	235	675
Children's	1,568	24	56	80
Total[f]	407,170	2,223	1.384	3,617
Scotland				
Voluntary	14,000	-	220	220
General Public	5,500	9	-	9
" Poor-law	1,700	(g)	-	(g)
Infectious Disease[h]	7,600	109	-	109
Tuberculosis Public	4,700	(g)	-	(g)
" Voluntary	600	-	(g)	(g)
Mental Public[i]	12,800	23	-	23
" Voluntary[i]	5,300	-	7	7
Maternity Public[e]	797	(g)	-	(g)
" Voluntary[e]	630	-	(g)	(g)
Registered Maternity Homes[e]	1,200	-	148	148
Total[f]	54,827			

Source: Ministry of Health, A National Health Service, (H.M. Stationery Office London, 1944), Appendix A, pp.55-61, 68-71; Twentieth Annual Report of Ministry of Health 1938-9, (H.M. Stationery Office, London, 1939), Appendix XI, p.245; Tenth Annual Report of Department of Health for Scotland, 1938, (H.M. Stationery Office, Edinburgh, 1939) pp. 75, 76, 190.

(a) Of which 250 had 50 or fewer beds, and 75 had over 200 beds.
(b) Of which 630 had 50 or fewer beds.
(c) Of which 30 had over 200 beds.
(d) Includes 13 registered hospitals and 49 licensed houses.
(e) 1937.
(f) An additional 51,000 emergency beds were provided during the war in England and Wales, and 15,000 in Scotland.
(g) Data not available.
(h) Of which 66 had 50 or fewer beds.
(i) 1943.

APPENDIX II

ESTIMATED STANDARDS OF HOSPITAL BED REQUIREMENTS BY REGION AND TYPE OF BED, ENGLAND, 1945.

Hospital Survey Area	Beds Needed per 1000 population					
	Acute	Chronic	Maternity	Isolation	Tuberculosis	Total
London[a]	5.0	1.25	0.4	0.8	0.8	8.25
Berks, Bucks, Oxon	5.0	2.5	0.6	0.8	1.0	9.9
Eastern Area[b]	3.5	2.0	0.4	0.6	0.6	7.1
East Midlands[c]	4.0	2.0	0.4	0.8	1.0	8.2
Yorkshire	4.0	2.0	0.5	1.0	1.0	8.5
South Western[d]	4.6	2.5	0.5	0.73	1.0	9.4
South Wales[e]	5.0	1.5	0.5	0.8	1.0	8.8

Source: Ministry of Health, Annual Report for 1945-46, (H.M. Stationery Office, London, 1947), p. 68.

(a) Includes Counties of Bedford, Dorset, Essex, Hants, Herts, Kent, London, Middlesex, Surrey and Sussex.
(b) Includes Cambridgeshire, Huntingdonshire, Norfolk, Suffolk, and Peterborough.
(c) Includes Derby, Leicester, Lincoln, Nottingham, Rutland, and the Southern part of West Yorkshire.
(d) Includes Cornwall, Devon, Gloucester, Somerset and Wiltshire.
(e) Includes Brecon, Cardigan, Carmarthen, Glamorgan, Pembroke, and Radnor, and also Monmouthshire.

ACTUAL SUPPLY OF HOSPITAL BEDS, BY REGION AND TYPE OF BED, ENGLAND, 1937.

Hospital Survey Area	Beds Available per 1000 population				
	General	Maternity	Isolation	Tuberculosis	Total
London	6.27	0.33	1.19	0.83	8.61
Berks, Bucks, Oxon	4.67	0.18	0.71	0.46	6.02
Eastern Area	4.53	0.19	0.70	0.94	6.36
East Midlands	4.11	0.27	0.72	0.73	5.83
Yorkshire	4.42	0.38	1.02	0.71	6.53
South Western	4.62	0.23	0.73	0.71	6.28
South Wales	3.48	0.21	0.78	0.71	5.18

Source: Ministry of Health. Twentieth Annual Report, 1938-39, (H.M. Stationery Office, London, 1939), Appendix XI, p. 245.

APPENDIX III

NUMBER OF BEDS, BY TYPE OF HOSPITAL, ENGLAND AND WALES AND SCOTLAND, 1948

Type of Hospital	England & Wales[a]	Scotland[b]	Great Britain
General Public	78,913		
General Voluntary	71,104		
Chronic Sick	80,178	22,778	281,987
Sick Children	7,953		
Other	21,061		
Infectious Disease	32,088		
Sanatoria & Tuberculosis	26,359	12,240	70,687
Maternity	7,375	2,698	10,073
Mental	140,401	21,965	162,366
Mental Deficiency Institutions	51,062	4,199	55,261
Total	516,494	63,880	580,374

Sources: Report of the Ministry of Health for 1947-48, Cmd. 7734, (HMSO, London, 1949), p. 276; Report of the Department of Health for Scotland, 1948, Cmd. 7659, (HMSO, Edinburgh, 1949), p. 27.

(a) As of March 31st, 1948.
(b) Including only those hospitals passing into State ownership as of July 5th, 1948. The most important exclusions are a Red Cross sanatorium and three Roman Catholic mental deficiency institutions.

APPENDIX IV

ESTIMATED NUMBER OF PERSONS ENTITLED TO HEALTH INSURANCE BENEFITS, BY SEX AND TYPE OF MEMBERSHIP, AND PER CENT OF TOTAL POPULATION
GREAT BRITAIN, 1923 and 1928-47.
(000's)

Year	MALES						FEMALES					TOTAL		
	Approved Societies	Navy, Army and Air Force Fund	Deposit Contributors	Persons over age 65(a)	Exempt Persons	Total	Approved Societies	Deposit Contributors	Persons over age 65(a)	Exempt Persons	Total(b)	Insured Persons	Per Cent of Population	Population
1923	9,880	175	178	227	30	10,490	4,942	91	37	10	5,080	15,570	36.0	43,291
1928	10,651	145	158	717	17	11,687	5,572	100	156	7	5,835	17,503	39.5	44,330
1929	10,780	135	154	762	16	11,846	5,661	105	171	8	5,945	17,791	40.0	44,439
1930	10,999	129	151	807	14	12,100	5,737	112	187	8	6,045	18,144	40.7	44,634
1931	11,102	124	150	849	13	12,238	5,759	113	204	8	6,085	18,392	40.9	44,795
1932	11,168	121	144	888	13	12,335	5,700	118	218	7	6,104	18,438	40.9	45,064
1933	11,039	118	138	929	12	12,235	5,713	123	233	7	6,076	18,310	40.5	45,202
1934	11,056	114	131	967	12	12,290	5,735	130	246	7	6,118	18,407	40.5	45,401
1935	11,199	120	130	1,007	11	12,466	5,789	132	261	7	6,190	18,656	40.9	45,598
1936	11,682	125	134	1,045	10	12,996	5,988	137	279	7	6,410	19,405	42.4	45,805
1937	11,920	126	140	1,083	8	13,278	6,118	146	294	7	6,565	19,851	43.1	46,006
1938	12,565	136	149	1,169	8	14,027	6,619	156	321	6	7,102	21,129	45.7	46,208
1939	12,804	136	141	1,223	7	14,311	6,779	154	337	6	7,276	21,587	46.5	46,467
1940	12,970	425	167	1,263	5	14,830	6,805	177	547	5	7,548	22,378	47.7	46,889
1941	13,044	514	194	1,310	3	15,065	7,237	205	591	4	8,080	23,145	49.4	46,875
1942	13,270	554	204	1,354	2	15,384	7,811	241	615	2	8,733	24,117	51.3	47,039
1943	13,295	587	201	1,394	2	15,479	8,144	270	643	2	9,131	24,610	52.0	47,300
1944	13,262	605	192	1,433	2	15,494	8,212	273	672	2	9,232	24,726	51.9	47,627
1945	13,221	621	169	1,458	2	15,471	8,110	255	701	1	9,141	24,612	51.5	47,791
1946	13,257	638	151	1,508	2	15,556	7,879	228	742	1	8,921	24,477	51.2	47,835
1947	13,246	644	357	1,557	1	15,505	6,986	613	785	1	8,443	23,948	49.7	48,189

Source: Annual Reports of the Ministry of Health, and the Department of Health for Scotland 1932 and 1938; Statistical Abstract for the U. K. 1935, Annual Abstract of Statistics, 1947; Report of the Ministry of National Insurance 1944-1949, (HMSO, London, 1950), p.98.

(a) For 1923 and 1928, these figures include only insured persons over age 70; after 1939, they include insured women over age 60.
(b) Female members of the Navy, Army and Air Force Fund are included in the totals for the years 1940-47.

APPENDIX V

RECEIPTS AND EXPENDITURES OF THE NATIONAL HEALTH INSURANCE FUND, GREAT BRITAIN, 1912-1947

(£ 000's)

Year	RECEIPTS				EXPENDITURES		
	Contributions	Exchequer Grants	Interest and Other	Total	Benefits	Administration	Total
1912-27	339,093	112,622	51,992	503,707	308,388	64,045	372,433
1928	25,979	7,135	5,710	38,824	32,310	5,263	37,573
1929	26,005	7,631	5,544	39,180	34,503	5,395	39,898
1930	26,039	7,335	6,043	39,417	32,931	5,660	38,591
1931	25,769	7,073	7,176	40,018	32,904	5,692	38,596
1932	25,030	6,184	6,064	37,278	31,875	5,592	37,467
1933	25,780	6,011	5,996	37,787	31,800	5,677	37,477
1934	26,649	6,176	6,095	38,920	30,421	5,588	36,009
1935	27,050	6,669	6,682	40,401	31,089	5,604	36,693
1936	28,269	7,090	6,363	41,722	32,625	5,710	38,335
1937	29,294	7,232	7,467	43,993	33,980	5,812	39,792
1938	29,879	7,506	6,859	44,244	33,972	5,988	39,960
1939	30,126	7,524	6,518	44,168	34,428	6,027	40,455
1940	30,606	7,620	6,711	44,937	34,207	5,893	40,100
1941	30,616	7,697	6,943	45,256	31,894	6,220	38,114
1942	38,708	8,688	10,302	57,698	39,635	6,528	46,163
1943	39,296	10,177	7,496	56,969	44,444	6,291	50,735
1944	38,388	10,841	7,591	56,820	46,310	6,467	52,777
1945	37,349	10,919	7,424	55,692	46,308	6,679	52,987
1946	38,019	11,311	7,467	56,797	49,738	7,333	57,071
1947	39,010	15,162	7,718	61,890	50,860	9,062	59,922

Source: Nineteenth Annual Report of the Ministry of Health, (HMSO, London, 1938), pp.282,304; Ninth Annual Report of the Dept. of Health for Scotland, (HMSO, Edinburgh, 1938), p.180; and Report of Ministry of National Insurance 1944-1949, (HMSO, London, 1950), p.97.

APPENDIX VI

PERCENTAGE DISTRIBUTION OF EXPENDITURE ON BENEFITS BY TYPE OF BENEFIT, NATIONAL HEALTH INSURANCE, 1912-27 COMBINED, SELECTED YEARS 1928-1947.

Year	Sickness Benefit	Dis-ablement Benefit	Maternity Benefit	Medical[a] Benefit	Additional[b] and Other Benefits	Total Benefits
	per cent	per cent	per cent	per cent	per cent	£000
1912-27	36.9	13.7	7.4	36.7	5.3	308,388
1928	34.9	19.1	5.4	31.2	9.4	32,310
1929	38.3	18.6	5.0	30.0	8.1	34,503
1930	33.8	19.3	5.5	31.2	10.2	32,931
1931	33.7	18.5	5.7	32.5	10.1	32,904
1932	34.7	19.7	5.4	31.3	9.0	31,875
1933	35.7	19.2	5.0	32.0	8.2	31,800
1934	32.3	20.9	5.2	33.1	8.5	30,421
1935	32.5	20.7	5.1	33.4	8.2	31,089
1936	32.8	20.0	5.1	33.3	8.8	32,625
1937	34.0	19.0	5.0	33.5	8.6	33,980
1938	30.8	18.8	5.1	36.1	9.2	33,972
1939	32.0	18.4	5.0	36.1	8.5	34,428
1943	42.6	16.6	4.6	31.1	5.1	44,444
1946	35.6	17.3	4.7	37.1	5.3	49,738
1947	31.2	16.7	5.1	41.4	5.6	50,860

Sources: Same as Appendix V

(a) See Appendix VII
(b) See Appendix VIII

APPENDIX VII

PERCENTAGE DISTRIBUTION OF EXPENDITURES ON MEDICAL BENEFITS, BY TYPE OF EXPENDITURE, GREAT BRITAIN, 1932-1938.

Year	ATTENDANCE BENEFITS			PHARMACEUTICAL BENEFITS		Other Expenditures(c)	Total Medical Benefits
	Capitation Payments	Mileage Payments	Rural Aid(a)	Chemists' Receipts	Practitioners' Receipts(b)		
	per cent	per cent	per cent	per cent	per cent	per cent	£ '000
1932	72.1	2.9	.1	21.6	2.2	1.1	9,970
1933	70.7	2.9	.1	20.7	2.2	3.4	10,165
1934	72.3	2.9	.1	20.9	2.2	1.6	10,071
1935	73.4	2.8	.1	20.8	2.1	.8	10,386
1936	73.2	2.6	.1	21.2	2.0	.9	10,851
1937	73.0	2.5	.1	21.4	1.9	1.1	11,368
1938	72.2	2.5	.2	21.2	2.0	1.9	12,259

Source: Annual Reports of the Ministry of Health and the Department of Health for Scotland (HMSO, London and Edinburgh) 1932-1938, passim.

(a) Aid to rural practitioners in providing telephones, automobiles, clinics, or in attending post-graduate courses.

(b) Payments to practitioners who were required to supply medicines and appliances in certain areas.

(c) Includes payments in respect of insured persons who had been authorized to get their treatment from institutions, or to make their own arrangements.

APPENDIX VIII

EXPENDITURE ON TREATMENT ADDITIONAL BENEFITS,
BY TYPE OF BENEFIT,
ENGLAND AND WALES 1928-1937, AND
GREAT BRITAIN 1938-1947.

(£ 000)

Year	Dental Benefit	Ophthalmic Benefit	Hospital Benefit	Convalescent Home Benefit	Medical & Surgical Appliances	Other Benefits	Total Additional Benefits
			ENGLAND and WALES				
1928	1,973	288	163	123	59	42	2,648
1929	1,825	288	202	110	64	41	2,530
1930	2,199	364	211	112	86	61	3,032
1931	2,107	428	164	104	90	58	2,951
1932	1,785	355	114	104	84	50	2,491
1933	1,579	359	107	108	85	49	2,287
1934	1,564	355	90	105	85	52	2,250
1935	1,513	361	89	105	89	56	2,212
1936	1,742	422	48	111	102	53	2,478
1937	1,789	434	33	106	103	70	2,536
			GREAT BRITAIN				
1938	2,160	512	47	118	127	98	3,062
1939	2,095	501	40	96	121	64	2,917
1940-44[a]	1,465	435	26	33	111	41	2,111
1946	1,724	61[illegible]	30	48	142	61	2,618
1947	1,710	700	30	65	170	65	2,740

Source: Sixteenth Annual Report of the Ministry of Health, (HMSO, London, 1935) p.246; Twentieth Annual Report of the Ministry of Health, (HMSO, London, 1939) pp.149, 213; Tenth Annual Report of the Department of Health for Scotland, (HMSO, Edinburgh, 1939) pp.141, 238; Report of the Ministry of National Insurance 1944 1949, (HMSO, London, 1950) p. 8[illegible].

(a) Average annual expenditures for these years.

APPENDIX IX

INSURED POPULATION, TOTAL REVENUE PER CAPITA, and PER CAPITA EXPENDITURE on ADMINISTRATION, BENEFITS, SICKNESS, DISABLEMENT, MATERNITY, and MEDICAL BENEFITS, GENERAL PRACTITIONER CAPITATION RECEIPTS, DRUGS, and SELECTED ADDITIONAL BENEFITS, in EACH of THE YEARS 1928-1939, 1943, 1946-47 PER CAPITA of INSURED POPULATION in GREAT BRITAIN

Year	Insured Popu-lation	Total Reve-nue	Expenditure			Sick-ness Bene-fits	Disable-ment Benefits	Mater-nity Bene-fits	Medical Benefits			Den-tal Bene-fits	Opnthal-mic Bene-fits	Hospi-tal Bens-fits	Other Addtl. Bene-fits
			Admin.	Bene-fits[a]	Total				Capi-tation Pay-ments	Drug Costs	Total[b]				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	'000's	s.	s.	s.	s.	s.	s.	s.	s.	s.	s.	d.	d.	d.	d.
1928	17,503	44.4	6.0	36.9	42.9	12.9	7.0	2.0	8.4(c)	2.8(c)	11.5	30.0	4.4(c)	2.5(c)	5.1(c)
1929	17,791	44.0	6.0	38.8	44.8	14.9	7.2	1.9	8.3(c)	2.8(c)	11.6	27.3	4.3(c)	3.1(c)	3.7(c)
1930	18,144	43.4	6.2	36.3	42.5	12.3	7.0	2.0	8.5(c)	2.8(c)	11.3	32.1	5.4(c)	3.1(c)	3.8(c)
1931	18,322	43.7	6.2	35.9	42.1	12.1	6.6	1.9	8.3(c)	2.8(c)	11.7	30.9	6.3(c)	2.4(c)	3.6(c)
1932	18,438	40.4	6.1	34.5	40.6	12.0	6.8	1.8	7.8	2.6	10.8	27.1	5.2(c)	1.7(c)	3.2(c)
1933	18,610	41.3	6.2	34.7	40.9	12.4	6.7	1.7	7.9	2.5	11.1	23.7	5.3(c)	1.6(c)	3.6(c)
1934	18,807	42.3	6.1	33.0	39.1	10.7	6.9	1.7	7.9	2.5	10.9	23.4	5.2(c)	1.3(c)	3.7(c)
1935	19,098	43.3	6.0	33.3	39.3	10.8	6.9	1.7	8.3	2.6	11.1	22.6	5.2(c)	1.3(c)	4.5(c)
1936	19,405	43.0	5.9	33.6	39.5	11.0	6.7	1.7	8.4	2.7	11.2	24.8	5.8(c)	.7(c)	4.7(c)
1937	19,851	44.3	5.9	34.2	40.1	11.6	6.5	1.7	8.5	2.7	11.4	25.1	5.9(c)	.5(c)	4.5(c)
1938	21,129	41.8	5.6	32.2	37.8	9.9	6.0	1.6	8.4	2.7	11.6	24.5	5.9	.6	6.2
1939	21,587	40.9	5.6	31.9	37.5	10.2	5.9	1.6	(d)	(d)	11.5	23.3	5.6	.4	3.1
1943	24,610	46.3	5.1	36.1	41.2	15.4	6.0	1.7	(d)	(d)	11.2	14.3	4.2	.2	2.9
1946	24,477	46.4	6.0	40.6	46.6	14.4	7.0	1.9	11.5(e)	3.4(e)	15.1	16.9	6.0	.3	3.2
1947	23,948	51.7	7.6	42.5	50.0	13.3	7.1	2.2	12.5(e)	5.0(e)	17.6	17.1	7.0	.3	3.2

Sources: Annual Reports of the Ministry of Health, Annual Reports of the Department of Health for Scotland, Report of the Ministry of National Insurance, 1944-49.

(a) Column 4 equals the sum of columns 6, 7, 8, 11, 12, 13, 14, 15.
(b) The figures in column 11 include those in columns 9 and 10 as well as amounts representing aid to rural doctors, mileage grants, etc.
(c) These figures apply to England and Wales only.
(d) Not available.
(e) Estimated.

M-419
6.52

APPENDIX X

NUMBERS AND CUMULATIVE PERCENTAGES OF NET INCOMES OF TAXPAYERS, GENERAL PRACTITIONERS, DENTISTS, AND SPECIALISTS, BY INCOME RANGE, GREAT BRITAIN, 1938.

Income Range	NET INCOMES							
	Taxpayers(a)		General Practitioners(b)		Dentists(c)	Specialists(d)		
	No.	Cumulative Per Cent	No.	Cumulative Per Cent	Cumulative Per Cent	No.	Cumulative Per Cent
£	000's						
0 -	-	-	130	1.8			
200 -	3078	74.8	420	7.6	19.8		
400 -	492	86.8	750	18.0	42.2		
600 -	182	91.2	1.09	33.3	57.4		
800 -	94	93.5	1243	50.5		381	23.5
1000 -			1090	65.6	79.1		
1200 -	112		821	77.0			
1400 -		96.2					
1500 -			656	86.1	89.5		
1600 -	51		370	91.2			
1800 -		97.4	243	94.5	94.3	585	59.6
2000 -			153	96.6			
2200 -	28		94	97.9	96.4		
2400 -		98.1					
2500 -			54	98.6			
2600 -	18		30	99.0			
2800 -		98.5	28	99.4		341	80.6
3000 -	20	99.0				150	89.9
4000 -	11	99.3				76	94.6
5000 -	7	99.5	41			40	97.1
6000 -	7	99.7				31	99.0
8000 -	4	99.8				6	99.4
Over 10,000	8	100.0		100.0	100.0	10	100.0
Total	4113(e)	100.0	7232	100.0	100.0	1620	100.0

Source: Eighty-third Report of the Commissioners of His Majesty's Inland Revenue for 1939-40, Cmd. 6769, (HMSO, London, 1946), p.30; Ministry of Health, Reports of the Inter-Departmental Committees on Remuneration of General Practitioners, Dentists, and Specialists, Cmd. 6810, 7402, 7420, (HMSO, London, 1946,1948) Chairman: Sir Will Spens.

(a) Fiscal year 1937-38.
(b) From a survey covering 7232 net incomes of general practitioners in practice during 1936-1938.
(c) From a survey concerning the net incomes of general dental practitioners aged between 35 and 54 in practice in cities during 1938.
(d) From a survey covering 1620 net incomes of specialists and consultants in practice during 1938.
(e) It is estimated that an additional 6.1 million persons received incomes of over £200 in 1938 but were relieved from paying tax by the operation of allowances. It should be noted that although only 10 million persons earned over £200 in 1938, 18½ million employed persons were insured under the National Health Insurance Act.

APPENDIX XI

AMOUNT AND PERCENTAGE DISTRIBUTION OF EXPENDITURE ON SOCIAL SERVICES, BY TYPE OF SERVICE, GREAT BRITAIN, YEAR ENDED 31st MARCH, 1939.

Type of Service	Amount (£000s)	Per Cent
Unemployment Insurance	69,734.	15.9
Health Insurance(1)	44,347.	10.1
Contributory Pensions	50,974.	11.6
Old Age Pensions	32,533.	7.4
Non-Contributory (Old Age) Pensions	15,056.	3.4
Blind Persons Pensions	815.	0.2
Blind Persons Assistance	2,077.	0.5
Unemployment Assistance	39,635.	9.1
War Pensions	37,000.	8.5
Workmen's Compensation	13,000.	3.0
Poor Relief	57,000.	13.0
Public Health(2)	59,174.	13.5
Lunacy and Mental Deficiency	16,539.	3.8
Total	437,884.	100.0

Source: Central Statistical Office, Annual Abstract of Statistics, 1937-1947, (London: HMSO. 1948), pp.215, 217. Sir William Beveridge, Social Insurance And Allied Services, (London: HMSO, 1942), p.241, Appendix G. p. 5.

(1) This figure apparently includes receipts that were invested by the Fund as well as expenditures on benefits and administration.

(2) Includes £21.5 million expenditure on hospitals, etc., and £24 million on sewage and refuse disposal, but excludes £11 million expenditure on parks and baths.

BIBLIOGRAPHY

BOOKS

CLARKE, Charles E. Social Insurance in Britain. Cambridge: University Press, 1950. Pp. 136.

COHEN, Percy. The British System of Social Insurance. New York: Columbia University Press, 1932. Pp. 278.

Economical Administration of Health Insurance Benefits. Geneva: International Labour Office, 1938. Pp. 332.

FÉRAUD, Lucien. Actuarial Technique and Financial Organisation of Social Insurance. Studies and Reports, Series M. (Social Insurance) No. 17. Geneva: International Labour Office, 1940. Pp. 568.

HARRIS, R.W. National Health Insurance in Great Britain 1911-1946. London: George Allen and Unwin Ltd., 1946. Pp. 224.

HARRIS, R.W. and SACK, Leonard Shoeten. Medical Insurance Practice. 4th ed. London: British Medical Association, 1937. Pp. 383.

The Hospitals Year-Book, 1947. London: Central Bureau of Hospital Information, the British Hospitals Association, 1947. Pp. 289.

LEVY, Hermann. National Health Insurance, A Critical Study. Cambridge: University Press, 1944. Pp. 366.

McCLEARY, G.F. National Health Insurance. London: H.K. Lewis & Co., 1932. Pp. 185.

MESS, Henry Adolphus, et al. Voluntary Social Services since 1918. International Library of Sociology and Social Reconstruction. Edited by Karl Mannheim. London: Kegan Paul, Trench, Trubner & Co., 1947. Pp. 255.

Report on the British Health Services. London: PEP. (Political and Economic Planning), 1937. Pp. 430.

ROBSON, William A. (ed.). Social Security. 3rd edition revised. Published for the Fabian Society by George Allen and Unwin Ltd. London, 1948. Pp. 475.

RUBINOW, I.M. Standards of Health Insurance. New York: Henry Holt and Company, 1916. Pp. 322.

SIMONS, A.M. and SINAI, Nathan. The Way of Health Insurance. Committee on the Study of Dental Practice of the American Dental Association, Publication No. 6. Chicago: University of Chicago Press, 1932. Pp.215.

OFFICIAL REPORTS

Chief Medical Officer of the Ministry of Health. Annual Reports On the State of the Public Health for the years 1935-1938. London: H.M. Stationery Office, 1936, 1937, 1938, 1939.

Commissioners of His Majesty's Inland Revenue. Eighty-Third Report for the Year ended 31st March, 1940. Cmd. 6769. London: H.M. Stationery Office, 1946.

Department of Health for Scotland. Annual Reports. 1932-1948. Edinburgh: H.M. Stationery Office.

Departmental Committee on Approved Societies' Administration Allowance. Report. Cmd. 1291. London: H.M.S.O., 1921.

Departmental Committee on Approved Society Finance and Administration. Interim Report and Further Report. Cd. 8251 and Cd. 8396. London: H.M.S.O., 1916.

Government Actuary. Report on the Financial Provisions of the National Health Insurance and Contributory Pensions Bill, 1935. Cmd. 4906. London: H.M.S.O., 1935.

_____ Interim Report upon the Valuation of the Assets and Liabilities of Approved Societies as at 31st December, 1918. Cmd. 1130. London: H.M.S.O., 1921.

_____ Report on the Second Valuation of the Assets and Liabilities of Approved Societies. Cmd. 2785. London: H.M.S.O., 1927.

_____ Summary Report on the Fifth Valuation of the Assets and Liabilities of Approved Societies, with a Supplement on Additional Benefit Schemes. Cmd. 6455. London: H.M.S.O., 1943.

Inter-Departmental Committee on Dentistry. Final Report. Cmd. 6727. London: H.M.S.O., 1946.

Inter-Departmental Committee on Health and Unemployment Insurance. Third Interim Report. Cmd. 1821. London: H.M.S.O., 1923.

Inter-Departmental Committee on Remuneration of General Practitioners. Report. Cmd. 6810. Sir Will Spens, Chairman. London: H.M.S.O., 1946.

Inter-Departmental Committee on Remuneration of General Dental Practitioners. Report. Cmd. 7402. Sir Will Spens, Chairman. London: H.M.S.O., 1948.

Inter-Departmental Committee on Remuneration of Consultants and Specialists. Report. Cmd. 7420. Sir Will Spens, Chairman. London: H.M.S.O., 1948.

Inter-Departmental Committee on Social Insurance and Allied Services. Report and Memoranda from Organizations. Cmd. 6404 and Cmd. 6405. Sir William Beveridge, Chairman. London: H.M.S.O., 1942.

Ministry of Health. Annual Reports. 1920 to 1949. London: H.M.S.O.

Ministry of National Insurance. Report for the Period 17th November 1944 to 4th July 1949. Cmd. 7955. London: H.M.S.O., 1950.

Royal Commission on National Health Insurance. Minutes of Evidence, Vols. I-IV; Appendix to Minutes of Evidence, Part I; Report. Cmd. 2596. London: H.M.S.O., 1924, 1925, 1926.

LEGISLATIVE PUBLICATIONS

British National Insurance Act, 1911. Bulletin of the United States Bureau of Labor, Whole Number 102. Workmen's Insurance and Compensation Series No. 2. Washington: Government Printing Office, 1912.

The Statutes, Regulations, and Orders relating to National Health Insurance. Part I - Statutes. 32-283-1. London: H.M. Stationery Office, 1929.

National Health Insurance Act, 1936. (26 Geo. 5 and 1 Edw. 8. Ch. 32.). London: H.M.S.O., 1936.

National Health Insurance, Medical Benefit Regulations, 1936. Statutory Rules and Orders, 1936, No. 1163. London: H.M.S.O., 1936.

National Health Insurance, Insurance Committees Regulations, 1937. Statutory Rules and Orders, 1937, No. 408. London: H.M.S.O., 1937.

National Health Insurance and Contributory Pensions, Collection of Contributions Regulations, 1938. Statutory Rules and Orders, 1938 No. 773. London: H.M.S.O., 1938.

Contributory Pensions, Collection of Contributions for Persons over Sixty-five Regulations, 1938. Statutory Rules and Orders, 1938 No. 816. London: H.M.S.O., 1938.

National Health Insurance, A Summary of the Acts for the Information of Members of Approved Societies. Memo. 239, 1938. London: H.M.S.O., 1938.

Provisional and Statutory Rules and Orders. 1941 Nos. 1105, 1970, 1983, 2093; 1942 Nos. 47, 80, 499, 637, 690, 817, 818, 1019, 1350, 2266, 2280, 2346, 2388, 2658, 2659, 2679, 2692, 2693, 2697; 1945 Nos. 833, 1695, 1696, 1698; 1946 No. 1558. London: H.M. Stationery Office.

OTHER PUBLIC DOCUMENTS

Approved Societies Handbook. 32-142-1-32. London: H.M.S.O., 1933.

Central Statistical Office. Annual Abstract of Statistics. No. 85, 1937-1947. London: H.M.S.O., 1948.

Health Services in Britain. 1947 and 1948 editions. Ottawa: United Kingdom Information Office. Pp. 38 and 23.

Memoranda Explanatory of the National Health Insurance Bills of 1911, 1917, 1928, and 1932. Cd. 5995, Cd. 8816, Cmd. 3051, Cmd. 4072. London: H.M.S.O.

Memorandum on Certification of Incapacity for Work, Giving the Results of Recent Investigations as to the Causes of Increase of Claims to Sickness and Disablement Benefit. Memo. 239/I.C. London: H.M.S.O. 1931.

McCLEARY, G.F. Memorandum on the English Scheme of National Health Insurance, with Special Reference to its Medical Aspects. London: H.M.S.O., 1929.

Ministry of Health. A National Health Service. Cmd. 6502. London: H.M.S.O., 1944.

National Health Insurance Fund Accounts, for the years ended 31st December, 1927, 1932, 1942. London: H.M.S.O., 1929, 1934, and 1944.

National Income and Expenditure of the United Kingdom, 1946 to 1949, and 1946 to 1950. Cmd. 7933 and Cmd. 8203. London: H.M.S.O., 1950 and 1951.

Official Representations by the British Medical Association regarding the Administration of Medical Benefit, and the Reply of the Joint Committee thereto. Cd. 6328. London: H.M.S.O., 1912.

Public Social Services. Cmd. 5609. London: H.M.S.O., 1937.

Statements as to the Administration of Medical Benefit and Correspondence thereon between the Chancellor of the Exchequer and the British Medical Association. Cd. 6520. London: H.M.S.O., 1912.

Statistical Abstract for the United Kingdom for each of the fifteen years 1913 and 1920 to 1933. Cmd. 4801. London: H.M.S.O., 1935.

PAMPHLETS AND ARTICLES

"Doctors and Population," British Medical Journal, August 26, 1950, pp. 502-3.

Medical Care for Citizens. PEP Pamphlets, No. 1. London: Europa Publications Limited, 1944. Pp. 32.

PUBLICATIONS IN THE SOCIAL SECURITY SERIES AND THE GENERAL SERIES
(Multilith)
Research Division, Department of National Health and Welfare

I SOCIAL SECURITY SERIES

Memorandum No. 1. Mothers Allowances Legislation in Canada. May 1949. 69 pp.

Memorandum No. 2. Old Age Income Security in New Zealand. March 1950. 41 pp.

Memorandum No. 3. Old Age Income Security in Australia. March 1950. 31 pp.

Memorandum No. 4. Old Age Income Security in Great Britain. March 1950. 84 pp.

Memorandum No. 5. Old Age Income Security in the United States. March 1950. 76 pp.

Memorandum No. 6. Old Age Income Security in Selected European Countries. (Denmark, France, Sweden, Switzerland). March 1950. 83 pp.

Memorandum No. 7. Social Security in Australia. July 1950. Estimated 150 pp.

Memorandum No. 8. Health Insurance in New Zealand. October 1950. 88 pp.

Memorandum No. 9. Health Insurance in Denmark. (Revised). February 1952. Estimated 65 pp.

Memorandum No. 10. Health Insurance in Sweden. January 1952. 76 pp.

Memorandum No. 11. Health Insurance in Great Britain, 1911-1948. March 1952. Estimated 120 pp.

Memorandum No. 12. Health Insurance in Norway. July 1952. Estimated 60 pp.

Memorandum No. 13. Health Insurance in the Netherlands. August 1952. Estimated 65 pp.

II GENERAL SERIES

Memorandum No. 1. Survey Dentists in Canada. 2nd ed., January 1949, 45 pp.

Memorandum No. 2. Survey of Physicians in Canada. 3rd ed., September 1948, 65 pp. 4th ed., September 1949, 61 pp.

M-419
6.52